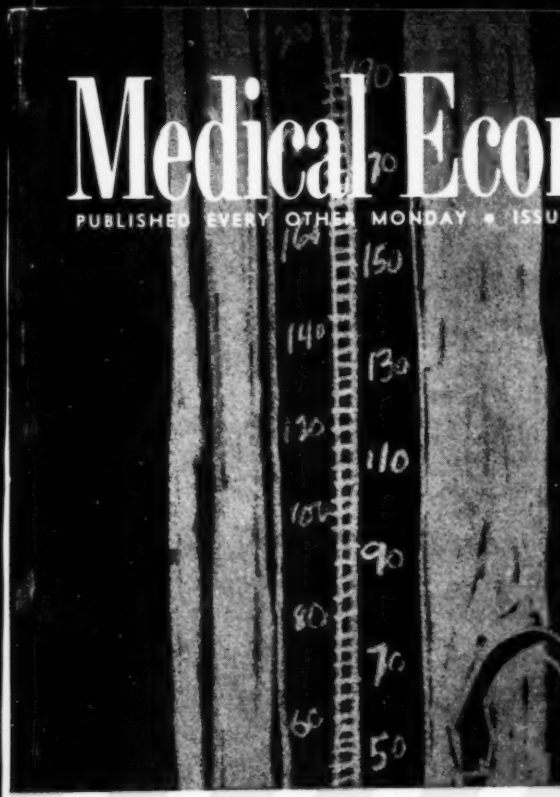
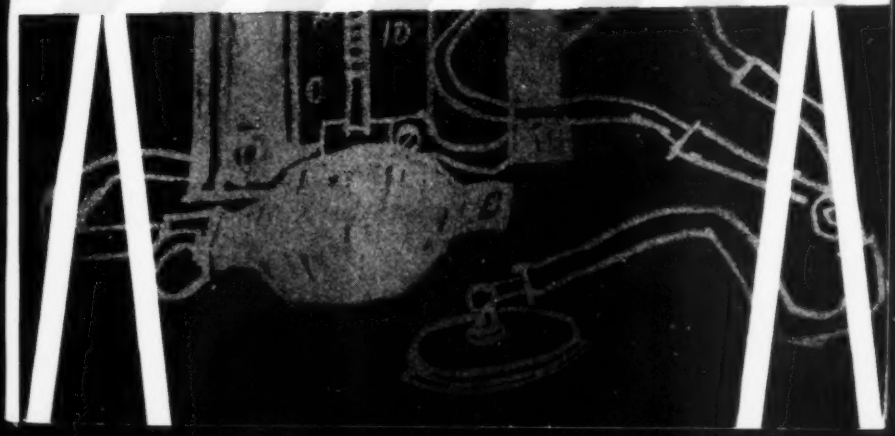
Medical Economics

PUBLISHED EVERY OTHER MONDAY • ISSUE OF AUGUST 1, 1960



How the Malpractice Threat Is Changing the Practice of Medicine



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Medical Economics

NEWS BRIEFS

NOT ALL M.D.s MAKE MONEY: A new I.R.S. report on physicians' tax returns for a recent year shows that of 136,623 men in solo practice, 8,135 (about 6%) had net losses totaling $12,705,000. The average net loss of these M.D.s was $1,560.

PHYSICALS FOR DRIVERS: Starting in 1962, Pennsylvania drivers will have to pass a physical every 10 years up to age 60, every 5 years thereafter.

EVERY MAN A BANKER: The Federal Housing Administration will now let individuals invest in F.H.A. mortgages. They pay upwards of 5% interest and are insured by the Government against default. The only catch: Your money might have to be tied up 20 years or more to earn the full interest.

WHAT COLLEGE COSTS: Here's the U.S. Office of Education's latest estimate of the average total cost of a year at college. Public institutions: $1,425. Private: $2,435 for men, $2,530 for women.

NEWS BRIEFS

FAIR FEES: A British Medical Assn. meeting has endorsed a rural delegate's plea that delivery fees be raised from the present $21. That sum, he said, is about $7 less than the Government bonus any local farmer gets when his cow has a calf.

HIGH COST OF BEING PRESIDENT: Dr. Franklin Yeager of Corpus Christi reports that his recent term as president of the Texas Medical Assn. cost him the following: $6,000 in loss of income; $1,850 for travel; and $600 for hotels, meals, etc. Of this $8,450, the T.M.A. defrays a maximum of $2,500.

OPPOSITION TO THE KEOGH BILL, which would let the self-employed set up tax-deferred pension plans, has mounted during Congress' recess. The Council of Profit Sharing Industries and the National Small Business Men's Assn. have both denounced the Senate version of the bill because it authorizes such pension plans only for employers who set up identical plans for all their employes.

LOOKING FOR AN INVESTMENT BARGAIN? Market Analysts Arthur Weisenberger & Co. report that although the net assets of many closed-end investment companies have risen in recent months, shares of the 10 leading firms are now selling at an average 16% below net asset value. Among the biggest bargains: Dominick Fund, Madison Fund, Tri-Continental Corp.

THERE'S LESS NEED FOR FARM-FAMILY DOCTORING, the new census shows. For the first time in history, fewer than 1 in 10 Americans are farm dwellers.

CHARGES OF MEDICAL MONOPOLY were hurled by feuding N.Y. doctors recently. Those associated with the closed-panel Health Insurance Plan of N.Y. charge that Staten Island's 3 voluntary hospitals have refused for 30 months to admit any new H.I.P. men to their staffs. The hospitals and non-H.I.P. doctors counter that the city-supported plan serves a "captive clientele." N.Y. Senator George R. Metcalf says he'll end the fight by legislation if necessary.

TAXPAYERS ARE FAILING TO DECLARE $1,000,000,000 in dividends annually, the Treasury Dept. said earlier this year. Now, after a new check, it says the present figure is only about half that high.

SMALLER DEPRECIATION DEDUCTIONS lie ahead for most M.D.s because of a new Supreme Court ruling. They can no longer use the declining-balance method to get fast write-offs on a business car, for example, unless they keep the car at least 3 years. Even then, they lose some additional tax breaks when selling it or trading it in. All this stems from the Court's definition of an asset's "useful life" as its period of use by the taxpayer, and its "salvage value" as its resale value after that period.

NEWS BRIEFS

TAX-COLLECTION FORECAST: I.R.S. Commissioner Dana Latham predicts that by 1965, when data-processing systems are installed in all I.R.S regional offices, "we'll collect about 90 per cent of the total amount [of taxes] assessed and determined."

CONTRIBUTE—OR ELSE! At a recent meeting called to discuss a lagging hospital fund drive, San Diego (Calif.) doctors were addressed by a specially invited labor leader. Whether his union asked management to build a closed-panel hospital for workers, he warned, would hinge on the success of the drive.

RULE BARRING HEARSAY EVIDENCE as unreliable in court has been upset in a recent N.J. medical case. The court ruled that a doctor whose patient had died from an industrial injury could testify as to how the patient said he'd been injured. "For the patient to state untruly to his doctor the cause of his physical debility," the Court said, "would be directly against his most vital interest."

"BANK-LOAN" LIFE INSURANCE UNDER FIRE: A plan that enables many doctors to afford additional insurance—borrowing from a bank to pay the premiums, then taking a tax deduction on the interest paid the bank—is under attack by the I.R.S. It has denied an Idaho man's deduction for just such a loan. The case will be decided by the Tax Court.

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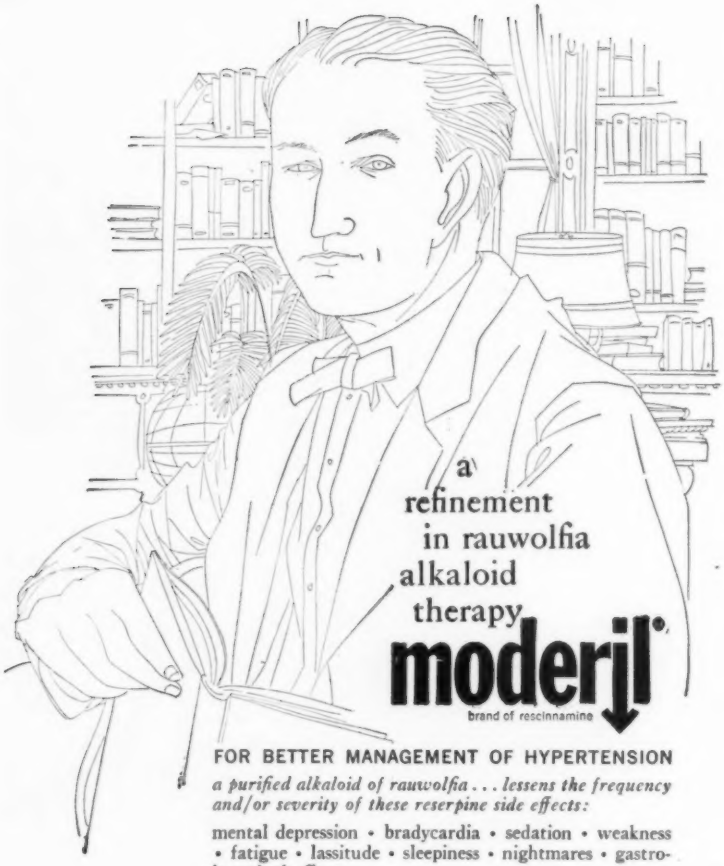

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Medical Economics

INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, AUG. 1, 1960

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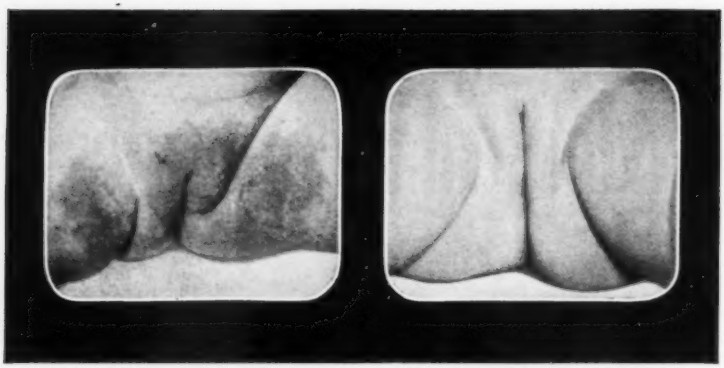

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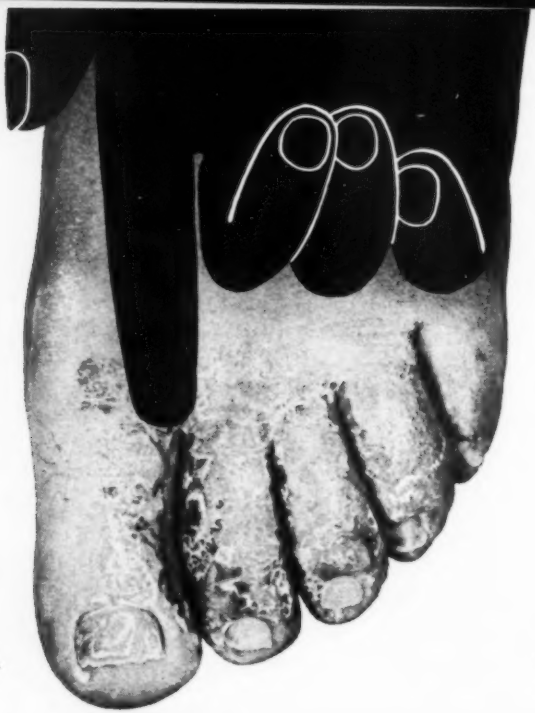

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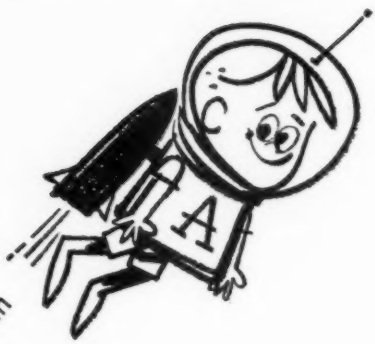

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References: W. J. Kolff, "Acute Renal Failure: Causes and Treatment," The Medical Clinics of North America, *30*:1052 (July 1955).
Peter Forsham, "Symposium on Adrenal Corticoid Therapy," Metabolism, *7*:19 (Jan. 1958).

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Letters

Medicine's Last Chance?

SIRS: When—not if—Congress enacts the first medical assistance program for senior citizens, we doctors will have about five years left before medicine becomes wholly governmentalized.

Right now may be our last chance to hammer out a program of medical care that permits free choice of physician, free choice of medication, free choice in the way to treat a patient. The Government will still listen and bargain with us now. Tomorrow? Who knows?

Werner Bergmann, M.D.
Oakland, Calif.

Two Kinds of Space

SIRS: Daniel Lang's "Man in Space" made a most interesting MEDICAL ECONOMICS book feature. But I wonder whether many other readers weren't struck, as I was, by the fact that so many scientists seem to be looking for π (pi) in the sky. The uncounted millions now being poured into space investigation might better be spent on the exploration of another kind of space—the space between the nucleus and its orbital electrons in the biological elements associated with, say, cancer or genetic disease.

Hyman H. Gordon, M.D.
Great Neck, N.Y.

Etiquette Isn't Enough

SIRS: The author of "How's Your Consultation Etiquette?" gave some good advice, but he seemed to forget one important person: the patient.

I don't think etiquette is nearly so important in referrals as is the question of which physician is best qualified to handle the case. Since the referring physician feels in need of help in making the diagnosis, he may often need help in carrying out the treatment, too.

Hugh A. Thompson, M.D.
Raleigh, N.C.

Tax Aid for Patients

SIRS: The patient who pays his medical bills in cash sometimes has trouble at income tax time remembering how much he has paid. I help solve his problem this way:

Whenever a bill is paid in cash, I prepare a regular statement, mark it paid, and file it. At the end of the year, I send these statements to the

Letters

patients concerned, thus providing them with a complete record of their cash payments to me.

This extra service costs me less than it does to mail out regular bills at the end of the month. And it pays off in patients' appreciation.

Peter Allen Bakal, M.D.
Scotia, N.Y.

Babies' Insurance Forms

SIRS: Why must insurance companies use the same complicated examination report forms for babies that they use for adults? I never can get used to seeing questions on blood pressure and use of cigarettes and alcohol when I'm reporting on a baby's physical. The forms ought to vary according to the age of the insured. Why don't the companies design some new ones?

Edward P. Benbow, M.D.
Greensboro, N.C.

Tips for Plaintiffs?

SIRS: Every once in a while, I see a patient reading a copy of MEDICAL ECONOMICS in some doctor's waiting room. With so many malpractice claims being brought

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321-60

Letters

against the medical profession, it's not a good idea to give patients an opportunity to bone up on the subject.

I make sure my copies are kept out of my patients' sight.

Monroe A. Rosenbloom, M.D.
Syracuse, N.Y.

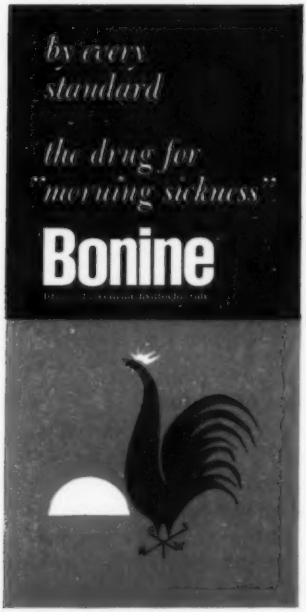
Good idea—and one the editors have repeatedly recommended. MEDICAL ECONOMICS *isn't meant for reception-room reading. Doctors who let it be used as such may well be multiplying their litigation risks.*—ED.

New Source of Nurses

SIRS: The medical profession has hunted high and low for people to fill the nursing shortage. But one big source of personnel has been pretty much overlooked. That's men.

Why aren't more men interested in the many positions that are now going begging for lack of qualified applicants? I think one of the main reasons is the stigma attached to the term "male nurse." It connotes a man doing a woman's job.

Yet anyone who has been in mil-



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INDICATIONS: Valuable in the symptomatic relief of nausea and vomiting of pregnancy. Also indicated for motion sickness, radiation sickness, vertigo associated with Ménière's syndrome, labyrinthitis, fenestration procedures, vestibular dysfunction, and dizziness associated with cerebral arteriosclerosis.

ADMINISTRATION AND DOSAGE: For control of nausea and vomiting of pregnancy, a daily dose of 25 to 50 mg. is usually effective. For dosage schedules in other indications, see package insert.

SIDE EFFECTS: Not a phenothiazine, the side effects reported in association with Bonine have been mild and/or transient and consist of occasional drowsiness, dryness of the mouth, and blurred vision. Drowsiness is seen less frequently with **BONINE** in therapeutic dosages than with most other effective antiemetics.

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Letters

itary service will testify to the courage and resourcefulness of the medics. So why not borrow that term? A good name like "medic" will sell the job much better than an unappealing one like "male nurse."

Seymour I. Kummer, M.D.
Rockville, Conn.

A Sign of Status?

SIRS: A patient who was visiting my office for the first time said, "You must be a good doctor." Since we had just met, I asked him how he could tell. "It's this diploma," he replied, pointing to my Army commission on the wall. "You were in the war."

I had planned to put the commission in the attic some time ago, but my wife insisted that I leave it on the wall. As long as it impresses some patient, I'll leave it up. And I'll listen to my wife more often.

S. C. Werch, M.D.
Miami, Fla.

Communications Snafu

SIRS: I was new in town, anxious to make a good impression. But something was wrong. For one thing, my partner told me on a couple of occasions that he'd been called the night before by one of *my* patients. For another, a num-

Continued on page 26

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1. Frech, H. C., and Lanier, L. R., Jr.: Am. J. Obst. & Gynec. 74:1146, 1957. 2. Way, W. G., et al.: Virginia M. Month. 85:291, 1958. 3. Hellman, L. D.: To be published.

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in edema or

▪ more doctors are prescribing—
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in congestive failure

"Chlorothiazide was given to 16 patients for a total of 295 patient-treatment days." "Chlorothiazide is a safe, oral diuretic with a clinical effect equal to or greater than a parenteral mercurial." Harvey, S. D. and DeGraff, A. C.: N. Y. State J. Med., **59**:1769, (May 1) 1959.

in hypertension

". . . our program has been one of polypharmacy in which we attempt to deplete body sodium with chlorothiazide. This drug is continued indefinitely as background medication for all antihypertensive drugs." Moyer, J.H.: Am. J. Cardiology, **3**:199, (Feb.) 1959.

in premenstrual edema

"Chlorothiazide is an excellent agent for relief of swelling and breast soreness associated with the premenstrual tension syndrome, since all patients [50] with these complaints were completely relieved." Keyes, J. W. and Berlacher, F. J.: J.A.M.A., **169**:109, (Jan. 10) 1959.

DOSAGE: Edema—One or two 500 mg. tablets DIURIL once or twice a day. Hypertension—One 250 mg. tablet DIURIL twice a day to one 500 mg. tablet DIURIL three times a day.

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hypertension

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in edema of pregnancy

"One hundred patients were treated with oral chlorothiazide." "In the presence of clinically detectable edema, the agent was universally effective." "Chlorothiazide is at present the most effective oral diuretic in pregnancy." Landesman, R., Ollstein, R. N. and Quinton, E. J.: N. Y. State J. Med., **59**:66, (Jan. 1) 1959.

in cirrhosis with ascites

"All three of the patients with Laennec's cirrhosis, ascites and edema had a favorable response, with a mean weight loss of 8 lbs., during the five-day treatment period with a slight decrease in edema." Castle, C. N., Conrad, J. K. and Hecht, H. H.: Arch. Int. Med., **103**:415, (March) 1959.

in renal edema

"In a study of 10 patients with the nephrotic syndrome associated with various types of renal disease, orally administered chlorothiazide was a successful, and sometimes dramatic, diuretic agent." Burch, G. E. and White, M. A., Jr.: Arch. Int. Med., **103**:369, (March) 1959.

MSD MERCK SHARP & DOHME
Division of Merck & Co., Inc., Philadelphia 1, Pa.

Letters

ber of patients had offhandedly said, "Gee, Doc, you're a hard man to get hold of." I couldn't understand any of this because I was nothing if not available. Then I finally saw the light:

A neighbor tried to make a social call to my wife. We weren't yet listed in the phone book, so she asked Information for our number. But in spite of her protests that she *knew* we had a telephone, she was told: "There is no Dr. Fulton listed."

And I *wasn't* listed! "A clerical error," the telephone company told me. Yes, it was inexcusable. And, yes, they were very sorry. But the damage was done.

I wonder how many patients were left with the impression that "you can never get hold of a doctor when you need one." And I wonder, too, whether there are other doctors in a similar fix without knowing it. It might be a good idea to check Information and make sure you're listed—especially if you're new in town.

Harold E. Fulton, M.D.
Port Huron, Mich.

END

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pregnancy

geriatrics

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adolescence

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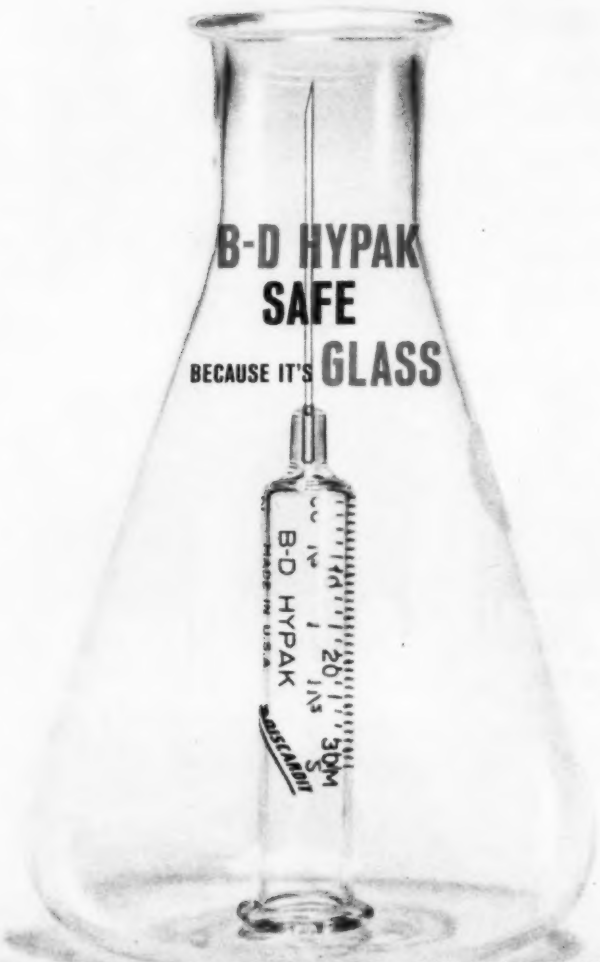

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News

Hospital Rates High? It's Doctors' Fault—Fivefold!

Why are hospital costs going up so fast? A committee studying that question has just come to "the inescapable conclusion that . . . medical influences . . . are five times as great a factor in the increase in hospital costs as all [others]."

It's not the "hotel costs" such as food and laundry that are sending up hospital bills, explains the New Jersey Blue Cross Rate Study Committee. Such costs "have increased but little over the years." But at the same time medical costs —resulting from the use of more equipment and more drugs—have been skyrocketing.

For that reason, add the committee's four members (none of them connected with Blue Cross), the extent to which "the administrator of [a] hospital can control his costs is to a very large extent dependent upon the demands and requirements of the attending physicians . . .

"Hospital boards do not, and doubtless even should not, make any effort to tell doctors how much can be spent on [hospital] medical care." Doctors should scrutinize the costs of such care themselves, says the committee. It warns:

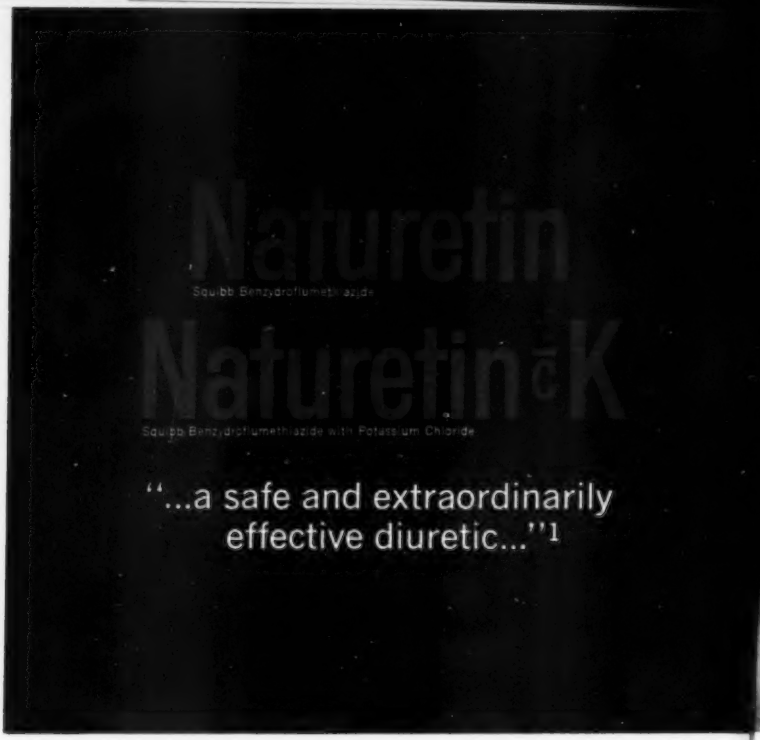
"The medical profession must accept the responsibility of devising controls on the monopoly it exercises in the areas of hospital utilization and hospital medical care . . . If Blue Cross and Blue Shield rates . . . get high enough to price themselves out of the market for the budget of the average citizen, the Government will then be encouraged to step in. And socialized medicine will become an accomplished fact."

'Federal Employe Benefits Are Costly—to Doctors'

The new health insurance program for Federal employes may bring more people under physicians' care. But in at least one state, it's disrupting the health care plan that doctors already have.

Rhode Island Physicians Service already covers more than two-thirds of the state's Federal employes and their dependents—mostly on an individual basis. When Uncle Sam's new program offered to pay part of the premiums for all Federal employes who

Continued on page 32



Naturetin—reliable therapy in edema and hypertension—maintains a favorable urinary sodium-potassium excretion ratio; retains a balanced electrolytic pattern:
"... the increase in urinary output occurs promptly ..."[1]
"... the least likely to invoke a negative potassium balance ..."[2]
"... a dose of 5 mg. of Naturetin produces a maximal sodium loss."[2]
"... an effective diuretic agent as manifested by the loss in weight..."[3]
"... no apparent influence of clinical importance on the serum electrolytes or white blood count."[3]
"... no untoward reactions were attributed to the drug."[4]

Numerous clinical studies confirm the effectiveness[1-15] of Naturetin as a diuretic and antihypertensive—usually in dosages of 5 mg. per day.

The most potent diuretic, mg. for mg.—more than 100 times as potent as chlorothiazide ■ prolonged action—in excess of 18 hours ■ maintains its efficacy as a diuretic and antihypertensive even after prolonged or increased dosage use ■ convenient once-a-day dosage—more economical for patients ■ low toxicity—few side effects—low sodium diets not necessary ■ not contraindicated except in complete renal shutdown ■ *in hypertension*—significant lowering of th

blood pressure. Naturetin may be used alone or with other antihypertensive drugs in lowered doses.

Although Naturetin causes the least serum potassium depletion as compared with other diuretics, the supplementary potassium chloride in Naturetin c̄ K provides added protection when treating hypokalemia-prone patients, patients with conditions where the likelihood of electrolyte imbalance is increased or during extended periods of therapy.

Supplied: Naturetin Tablets, 5 mg. (scored) and 2.5 mg. Naturetin c̄ K (5 c̄ 500) Tablets (capsule-shaped) containing 5 mg. benzydroflumethiazide and 500 mg. potassium chloride. Naturetin c̄ K (2.5 c̄ 500) Tablets (capsule-shaped) containing 2.5 mg. benzydroflumethiazide and 500 mg. potassium chloride.

"NATURETIN" IS A SQUIBB TRADEMARK.

References: 1. David, N. A.; Porter, G. A., and Gray, R. H.: Monographs on Therapy *5*:60 (Feb.) 1960. 2. Stenberg, E. S., Jr.; Benedetti, A., and Forsham, P. H.: Op. cit. *5*:46 (Feb.) 1960. 3. Fuchs, M.; Moyer, J. H., and Newman, B. E.: Op. cit. *5*:55 (Feb.) 1960. 4. Marriott, H. J. L., and Schamroth, L.: Op. cit. *5*:14 (Feb.) 1960. 5. Ira, G. H., Jr.; Shaw, D. M., and Bogdonoff, M. D.: North Carolina M. J. *21*:19 (Jan.) 1960. 6. Cohen, B. M.: M. Times, to be published. 7. Breneman, G. M., and Keyes, J. W.: Henry Ford Hosp. M. Bull. *7*:281 (Dec.) 1959. 8. Forsham, P. H.: Squibb Clin. Res. Notes *2*:5 (Dec.) 1959. 9. Larson, E.: Op. cit. *2*:10 (Dec.) 1959. 10. Kirkendall, W. M.: Op. cit. *2*:11 (Dec.) 1959. 11. Yu, P. N.: Op. cit. *2*:12 (Dec.) 1959. 12. Weiss, S.; Weiss, J., and Weiss, B.: Op. cit. *2*:13 (Dec.) 1959. 13. Moser, M.: Op. cit. *2*:13 (Dec.) 1959. 14. Kahn, A., and Greenblatt, I. J.: Op. cit. *2*:15 (Dec.) 1959. 15. Grollman, A.: Monographs on Therapy *5*:1 (Feb.) 1960.

SQUIBB

Squibb Quality—the Priceless Ingredient

News

bought group coverage instead, the plan decided to offer them such coverage, too. But first it had to meet some rigid Federal regulations. And this meant changing some of the plan's basic features.

Who will benefit from these changes? Everyone except the doctor, laments the Rhode Island Medical Journal; he's "the loser all round in this arrangement." In explaining why, the journal points a finger at several groups who may well gain at the doctors' expense:

¶ All Rhode Islanders in certain income brackets who *don't* work for the Federal Government. One change made by the plan was to raise to $6,000 the income ceiling for families who can receive service benefits under its maximum program. Another change was to raise to $4,000 this income ceiling for its minimal program. The families whose income was between the new and the old ceilings used to get indemnity benefits. Now—at no extra cost—they get service benefits.

¶ All Federal employes in the state who use the new program to buy indemnity benefits from a private company. Many will doubtless compare notes with fellow workers who've bought from Physicians Service. And these fellow workers in most cases won't have

Continued on page 37

XYLOCAINE

LOCAL & TOPICAL ANESTHETIC

suturing: Xylocaine® HCl Solution applied topically will permit cleaning and suturing of wounds with patient comfort in an emergency or in the office. Fast acting – Safe – Dependable.

bursitis: Xylocaine HCl Solution injected into the painful area will diffuse around the bursae relieving pain promptly – often restoring normal freedom of motion. Prolonged anesthesia often prevents recurring pain.

therapeutic block: Xylocaine HCl Solution interrupts the underlying mechanism of pain, with relief often persisting even after the block has disappeared. It is of value in assisting motion or manipulation; for severe, intractable pain conditions; and in allowing patient comfort for other procedures.

minor surgery: Xylocaine HCl Solution will diffuse over a wide operative field, permitting pain-free removal of warts, cysts, moles, etc., and giving safe, effective, and predictable anesthesia for patient comfort.

Supplied: Multiple dose vials, 20 cc. and 50 cc.; 0.5%, 1% and 2% without and with epinephrine 1:100,000. Ampules, 2 cc.; 2% without and with epinephrine 1:100,000.

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*U.S. PAT. NO. 2,441,498

MADE IN U.S.A.

Schering

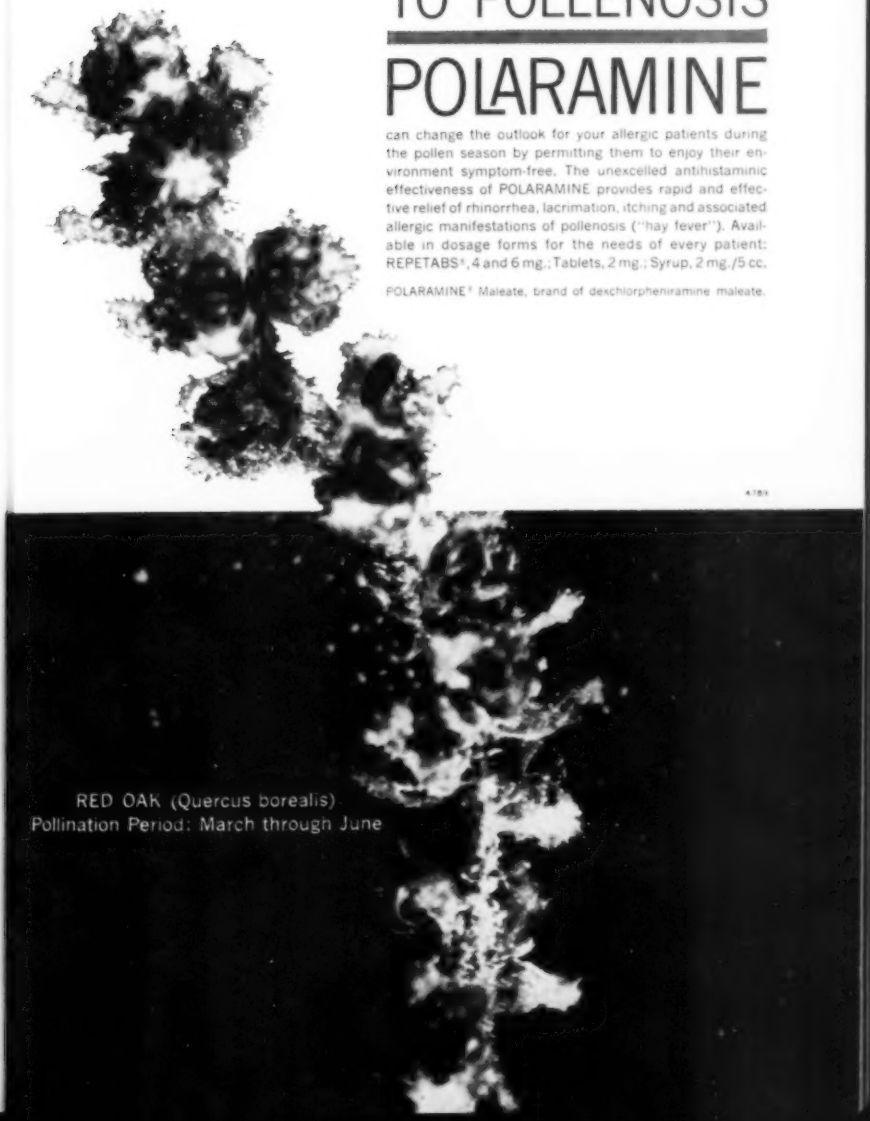
FROM POLLEN TO POLLENOSIS

POLARAMINE

can change the outlook for your allergic patients during the pollen season by permitting them to enjoy their environment symptom-free. The unexcelled antihistaminic effectiveness of POLARAMINE provides rapid and effective relief of rhinorrhea, lacrimation, itching and associated allergic manifestations of pollenosis ("hay fever"). Available in dosage forms for the needs of every patient: REPETABS®, 4 and 6 mg.; Tablets, 2 mg.; Syrup, 2 mg./5 cc.

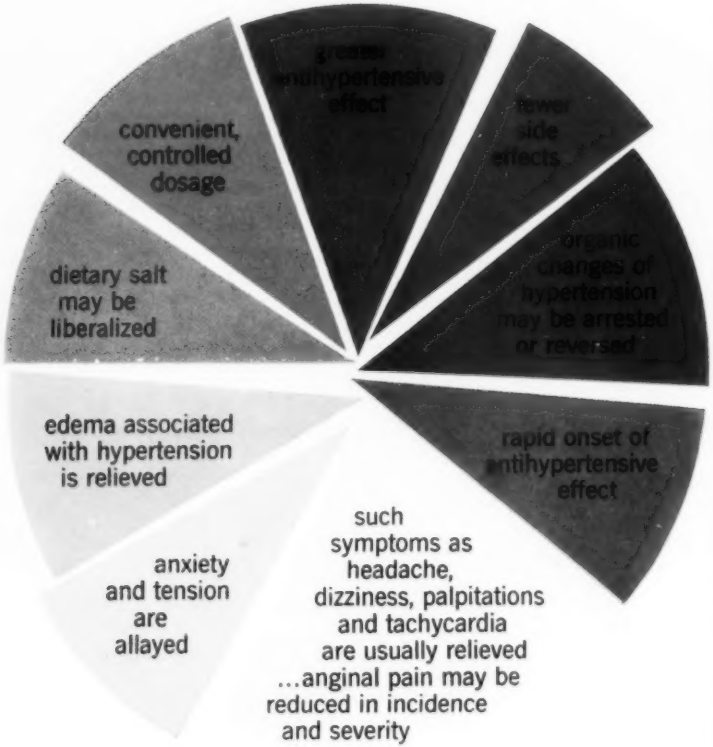
POLARAMINE® Maleate, brand of dexchlorpheniramine maleate.

4784



RED OAK (Quercus borealis)
Pollination Period: March through June

here are some of the ways hypertensive patients benefit when you prescribe DIUPRES



the first "wide rang[illegible]

DIUPRES

DIURIL® WITH RESERPIN[illegible]

effective by itself in a majority of patients with mild or moderate hypertension, and even in many with severe hypertension... should other drugs need to be added, they can be given in much lower than usual dosage

DIUPRES-250

250 mg. DIURIL (chlorothiazide),
0.125 mg. reserpine per tablet.
One tablet one to four times a day.

DIUPRES-500

500 mg. DIURIL (chlorothiazide),
0.125 mg. reserpine per tablet.
One tablet one to three times a day.

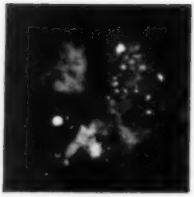
For additional information, write Professional Services, Merck Sharp & Dohme, West Point, Pa.

MERCK SHARP & DOHME, DIVISION OF MERCK & CO., INC., WEST POINT, PA.

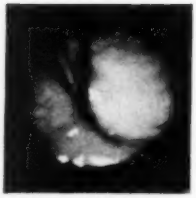
DIUPRES and DIURIL are trademarks of Merck & Co., Inc.

Excellent results in ulcerative colitis even where other steroids have failed

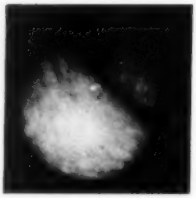
Proctoscopic view of the sigmoid in acute stage of ulcerative colitis



Proctoscopic view of the sigmoid following Depo-Medrol retention enemas for acute stage of ulcerative colitis



Proctoscopic view of sigmoid colon in a normal person



In controlling ulcerative colitis (recurrent, moderately severe, severe, and resistant), Depo-Medrol†can be given topically (by enema or rectal instillation) in requisitely large doses without producing significant side effects. Excellent results are obtainable even where other steroids have failed and improvement continues on oral Medrol maintenance dosage.

there is only one methylprednisolone, and that is

Medrol*

the corticosteroid that hits the disease, but spares the patient

Medrol is supplied as 4 mg. tablets in bottles of 30, 100 and 500; as 2 mg. tablets in bottles of 30 and 100; and as 16 mg. tablets in bottles of 50. Depo-Medrol is supplied as 40 mg. per cc. injectable suspension in 1 cc. and 5 cc. vials. Mode of administration: Depo-Medrol (40-120 mg.) given as retention enema or by continuous drip three to seven times weekly.

*Trademark, Reg. U. S. Pat. Off.—methylprednisolone, Upjohn †Trademark

to pay *any* part of their lower medical fees. So employes who have indemnity benefits may put up a fuss when they're asked to pay part of a higher fee.

• All private companies who sell insurance to Federal employes in the state. Compared with Physicians Service, these companies are in a position to collect a higher premium from Uncle Sam. So they may be able to offer more benefits. And, in turn, they may attract more Federal employes.

Doctors in the state went into the Federal employes' program as a public service. But it may prove to be a service costly to the physicians, warns the Rhode Island Medical Journal: "The doctor, a major purveyor of the services to be purchased, may have bought himself an expensive seat on the sidelines."

Canadian Investments Good As Canadian Dollar Dips

For the last eight years, the Canadian dollar has commanded a premium in terms of U.S. money. As recently as last April, the Dominion's dollar was worth nearly $1.05

Continued on page 40

"Gratifying" relief from s

for your patients with
'low back syndrome' and
other musculoskeletal disorders

POTENT muscle relaxation
EFFECTIVE pain relief
SAFE for prolonged use

n stiffness and pain

"gratifying" *relief from stiffness and pain in 106-patient controlled study*

(as reported in J. A. M. A., April 30, 1960)

"Particularly gratifying was the drug's [SOMA's] ability to relax muscular spasm, relieve pain, and restore normal movement... Its prompt action, ability to provide objective and subjective assistance, and freedom from undesirable effects recommend it for use as a muscle relaxant and analgesic drug of great benefit in the conservative management of the 'low back syndrome'."

Kestler, O.: Conservative Management of "Low Back Syndrome", J.A.M.A. 172: 2039 (April 30) 1960.

FASTER IMPROVEMENT—79% complete or marked improvement in 7 days (Kestler).

EASY TO USE—Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

SUPPLIED: 350 mg., white tablets, bottles of 50.
For pediatric use, 250 mg., orange capsules, bottles of 50.
Literature and samples on request.

SOMA®
(CARISOPRODOL WALLACE)

WALLACE LABORATORIES, CRANBURY, NEW JERSEY

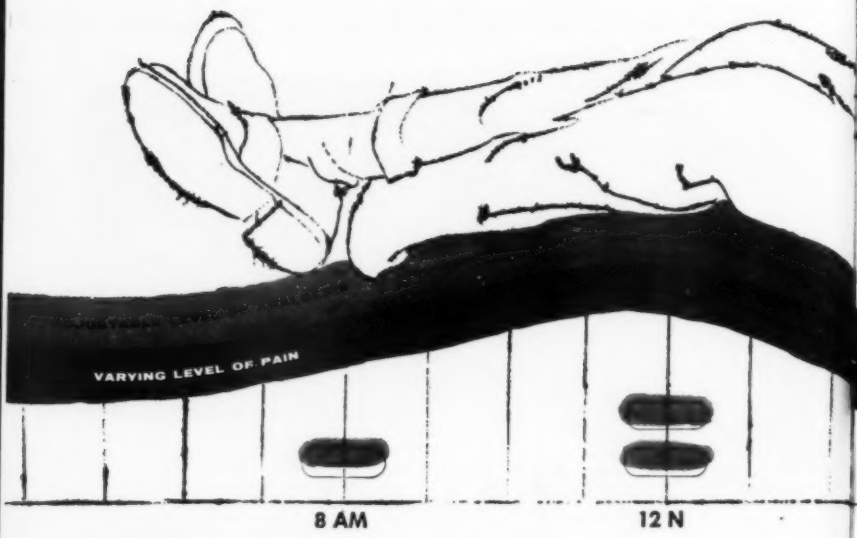
in our currency. Since then, its value has dropped sharply, until now the two currencies are almost on a par.

For most of Canadian industry, the new exchange parity is a blessing. The premium on the Canadian dollar was good for the country's national pride but bad for its business. Canada's great export industries—paper, metals, raw materials—in particular were hurt. That was because the companies in those export industries collected for their U.S. sales in 100-cent dollars but had to pay their own bills in 105-cent dollars.

What does the new parity mean to the American doctor interested in buying Canadian stocks, mutual funds, or bonds? There are now eight mutual funds offered in the U.S. that concentrate on Canadian investments. Anything that helps Canadian companies, the fund managers point out, is also likely to help the mutual funds investing in those companies. And by the same token, Canadian stocks are being bolstered by the parity.

U.S. doctors who have invested in Canadian bonds, attracted by

Continued on page 44



keep all patients* pain-free at all times

- with the proper potency to match pain intensity
- with dosage flexibility to match pain variations

Phenaphen®

or

Phenaphen® with Codeine

*except those for whom recourse to morphine is inescapable

Robins

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA

Ethical Pharmaceuticals of Merit since 1878

Phe
Basic
For m
Each
Acetyl
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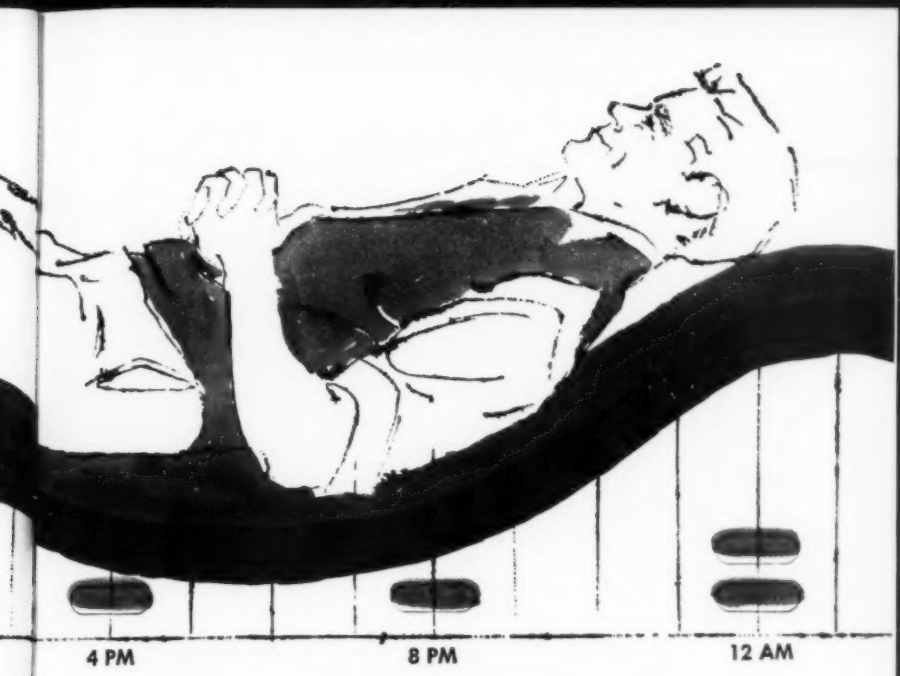


Phenaphen and Phenaphen with Codeine provide a wide range of analgesia, plus complete dosage flexibility, to match varying pain requirements.

Yours to prescribe:

The **right** dose of the **right** potency at the **right** time.

Phenaphen

Basic non-narcotic formula

For mild to moderate pain

Each capsule contains:

Acetylsalicylic acid (2½ gr.)	162.0 mg.
Phenacetin (3 gr.)	194.0 mg.
Phenobarbital (¼ gr.)	16.2 mg.
Hyoscyamine sulfate	0.031 mg.

Phenaphen No. 2

Phenaphen with Codeine Phosphate ¼ gr. (16.2 mg.)

For moderate to severe pain

Phenaphen No. 3

Phenaphen with Codeine Phosphate ½ gr. (32.4 mg.)

For severe or stubborn pain

Phenaphen No. 4

Phenaphen with Codeine Phosphate 1 gr. (64.8 mg.)

For stubborn or intense pain—to obviate or postpone use of morphine or addicting synthetic narcotics

DOSAGE: One or two capsules as required.

the high 6 per cent rates offered recently, have less cause to cheer. A man who bought a $1,000 Canadian bond a year ago had to pay about $1,050 in U.S. money at the then-going rate of exchange. If he had to cash the bond now, he'd get back little more than $1,000.

High Bank Rates Spur Use Of Life Insurance Loans

Doctors who are thinking of borrowing money on their life insurance policies have plenty of company these days. According to The Wall Street Journal, such loans have jumped 42 per cent in the first quarter of this year over the same period in 1959.

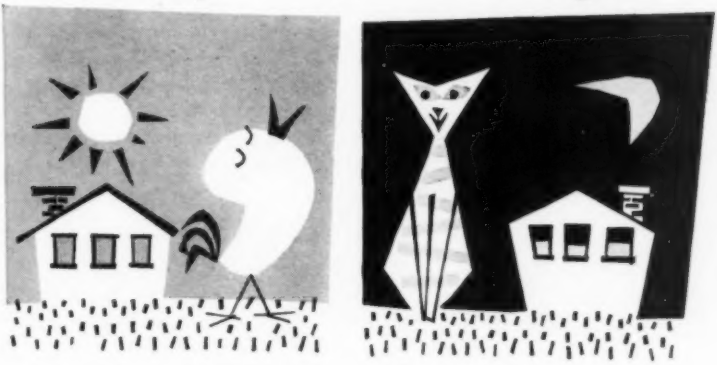
Why the rush for life insurance loans? For one thing, bank rates have been going up. And this has made people more aware of these advantages of life insurance loans:

¶ They're inexpensive. Commercial policies usually specify a 5 per cent interest rate on loans; G.I. insurance, a 4 per cent rate. By contrast, bank loans to doctors are likely to cost 6 per cent or more.

¶ They're easy to negotiate. That's because a doctor who applies for a life insurance loan al-

Just one (1) capsule tranquilizes

all day or all night



Here is *single-capsule convenience* for your tense, nervous patients.

One capsule at breakfast relieves both mental and muscular tension *all through the day.*

One capsule in the evening provides restful sleep *all through the night.*

Prescribe Meprospan for safe and convenient *sustained* tranquilization . . . less trouble for your patient, less chance to forget medication.

Meprospan®-400

400 mg. Miltown® continuous release capsules

Supplied: *Meprospan-400*, each blue-topped, *continuous release* capsule contains 400 mg. Miltown (meprobamate, Wallace).

Also available: *Meprospan-200*, each yellow-topped, *continuous release* capsule contains 200 mg. Miltown.

WALLACE LABORATORIES/*Cranbury, N. J.*

CME-2192

ready has more than the amount of the loan in accumulated cash values. So no credit references are needed. Some doctors have been able to borrow as much as 95 per cent of a policy's cash value while keeping their policies in force.

• They're speedy. The borrower gets his check a few days after the insurance company gets his application.

• They don't have to be paid back fast. In fact, they really don't have to be paid back at all. (Doctors are generally advised to repay at least part of such loans, however, to prevent their policies from losing too much value.)

When bank rates are lower than they are now, life insurance loans are usually advised only as a last resort. For if a borrower dies before paying back such a loan, the outstanding balance is deducted from the sum due his beneficiary.

M.D.-Run Polio Clinic Says No to D.O.-Volunteers

Is it ethical for M.D.s to participate in a polio immunization clinic with osteopaths? That question came up recently when some osteopaths offered to lend a hand with the dollar-a-shot polio clinics run by the Passaic County (N.J.) Medical Society. In a quandary, the county society turned to its state medical society's judicial council for an answer.

Ruled the council: Such an association of M.D.s and osteopaths is clearly unethical. If D.O.s want to give community-wide polio shots, "it might be advisable [for them] to set up their own separate clinics, which would be operated solely by osteopaths, and in which the doctors of medicine could not associate."

Most Nurses Don't Expect Discounts From Doctors

Should a nurse expect to receive a professional courtesy discount when she goes to a doctor for treatment? According to a recent survey made by the magazine RN, three out of four nurses say no.

The survey also reveals that most nurses select a physician on the basis of professional competence. Half say they pick M.D.s they've worked with professionally. As for the special qualities they look for, "courtesy and personal attention" rate highest. The last thing they want is "cold, assembly-line treatment."

Don't Pay for Diagnosis, Court Tells Blue Cross

Suppose a doctor sends a patient to a hospital and orders nothing for him except a battery of diagnostic

Continued on page 50

A TRUE SOLUTION FOR FAST RELIEF OF RHINITIS...

NEO-HYDELTRASOL®

PREDNISOLONE 21-PHOSPHATE WITH PROPADRINE®, PHENYLEPHRINE AND NEOMYCIN

NASAL SPRAY

■ The only nasal spray with prednisolone 21-phosphate in true solution—to make more steroid available more promptly ■ The complementary activity of 2 nasal decongestants—Propadrine® and phenylephrine ■ The potent, quick-acting antibiotic—neomycin . . . with minimal 'rebound' engorgement ■ Supplied in 15 cc. plastic spray bottles ■ Neo-Hydeltrasol and Propadrine are trademarks of Merck & Co., Inc.

MSD MERCK SHARP & DOHME
Division of Merck & Co., Inc., West Point, Pa.

how flexible should a hypoallergenic formula be?

A formula for milk-allergic infants should be flexible enough to permit a suitable formula pattern for every individual need. MULL-SOY *fits the formula to the child – not the child to the formula.*

Consider, for example, the baby whose frequent upsets require continuing formula adjustment . . . the baby with diarrhea requiring a low sugar intake . . . or the older infant beyond actual formula stage for whom carbohydrate modification is not necessary.

Well accepted in color and flavor, MULL-SOY best fulfills the need for formula flexibility because it does *not* provide a fixed *total* carbohydrate content. Formula construction to suit the needs of the individual infant is always possible. As with evaporated milk, MULL-SOY leaves the choice of added carbohydrate, quantity of carbohydrate, and degree of dilution to the physician's discretion. Finally, MULL-SOY provides well-tolerated protein for good growth, a lipid content high in linoleic and other important unsaturated fatty acids, plus dependable relief from milk-allergy manifestations.

ADVERTISEMENT

when cow's milk sensitivity disrupts infant feeding

Mull-Soy®

LIQUID / POWDERED

the flexible hypoallergenic soybean base with the documented tolerance potential...for sound, well tolerated nutrition suited to the needs of *each* case

Liquid—
15 1/2-fl.oz. tins;

Powdered—
1-lb. tins.

Borden's PHARMACEUTICAL DIVISION, 350 Madison Avenue, New York 17, N. Y.

tests. Should Blue Cross foot the bill? No, according to the recent ruling of a New York State appellate court.

The case concerned a patient who was suing to get Blue Cross to pay the bill for his nine-day hospital stay. During that time, he'd had a lot of diagnostic tests but no operation. His Blue Cross contract covered admissions primarily for treatment, but not admissions primarily for diagnosis. Which kind of admission was this?

For treatment, said the patient. He claimed that his hiatus hernia had already been diagnosed as such long before he reached the hospital. His anticipated operation in the hospital was made unnecessary by other treatment there, he contended.

The Blue Cross lawyer disputed this. He quoted the patient's hospital record to show that (1) when the patient was admitted, seven other conditions besides hiatus hernia were noted as possibilities; (2) the patient on admission had signed a consent form for diagnostic procedures but not one for surgery; (3) the patient hadn't actu-

Continued on page 54

Fostex®
treats their acne while they wash

completely emulsifies and washes off excess oil from the skin.

penetrates and softens comedones, unblocks pores and facilitates removal of sebum plugs.

removes papule coverings and permits drainage of sebaceous glands.

Patients like Fostex because it is so easy to use. They simply wash acne skin 2 to 4 times a day with Fostex Cream or Fostex Cake, instead of using soap.

Fostex contains Sebulytic®,* a combination of surface-active wetting agents with remarkable antiseborrheic, keratolytic and antibacterial actions . . . enhanced by sulfur 2%, salicylic acid 2%, and hexachlorophene 1%.

*sodium lauryl sulfoacetate, sodium alkyl aryl polyether sulfonate and sodium dioctyl sulfosuccinate.

Fostex is available in two forms—

FOSTEX CREAM, in 4.5 oz. jars.
FOSTEX CAKE, in bar form.

Fostex Cream and Fostex Cake are interchangeable for therapeutic washing of the skin. Fostex Cream is approximately twice as drying as Fostex Cake.

Fostex Cream is also used as a therapeutic shampoo in dandruff and oily scalp.

Write for samples.

WESTWOOD PHARMACEUTICALS • Buffalo 13, New York

M-275

ALPEN is the oral penicillin that provides, on a fasting stomach, peak antibiotic blood levels approximately twice as high as oral potassium penicillin V... and significantly higher than I. M. penicillin G.

Some strains of staphylococci resistant to other penicillins exhibit in vitro sensitivity to potassium phenethicillin.

ALPEN has greater freedom from the G. I. sequelae (overgrowth of resistant flora) sometimes observed with broad spectrum-mycins.

ALPEN gives much higher antibiotic levels within the first hour of ingestion by the well-tolerated oral route.

WHEN TO USE ALPEN Recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci.

HOW TO USE ALPEN Depending on the severity of the infection, 125 mg. (200,000 units) or 250 mg. (400,000 units) three times daily may be used. In more severe or stubborn infections, a dosage of 500 mg. (800,000 units) t.i.d. may be employed. In beta hemolytic streptococcal infections, treatment should be continued for at least ten days.

PRECAUTIONS The usual precautions in the administration of oral penicillin should be observed. For further details see package literature.

Tablets: 125 mg. and 250 mg., bottles of 25 and 100.
Powder for Oral Solution (lemon-lime flavored), 1.5 Gm. bottle (125 mg. per 5 cc. teaspoonful).

this is the tablet that gives higher peak antibiotic blood levels

HIGHER THAN I. M. PENICILLIN G
HIGHER THAN POTASSIUM PENICILLIN V

ALPEN

ALPEN™—potassium phenethicillin

Schering

ally been treated with any medication except a sedative; (4) the patient while in the hospital had been given sixteen different diagnostic tests.

A lower court had decided the case in favor of the patient. It did so on grounds that the patient may well have recovered in the hospital because of his "separation from care and responsibility." But the appellate court saw it differently. It sided with the Blue Cross lawyer who said: "Common sense alone attests to the inescapable fact that [Blue Cross] would quickly be out of business if it undertook to finance rest cures for its subscribers."

Report Treats Hospitals As a Public Utility

Doctors in one state may soon have to give a public accounting of the way they use their hospitals. Thus, if representatives of the public feel that an institution is running inefficiently, they'll be able to slice the rate of payment that hospital gets from Blue Cross.

This is what will happen if the proposals of the Trussell report are implemented by law. Dr. Ray

anorectal comfort

To shorten total treatment time in hemorrhoids, proctitis and pruritus ani, *start* treatment with Anusol-HC (2 suppositories daily/3-6 days) — then *maintain* lasting comfort with regular Anusol (1 suppository morning, evening and after each bowel movement). Neither product contains analgesics or narcotics, will not mask symptoms of serious rectal pathology.

Anusol®
hemorrhoidal suppositories and unguent

WARNER CHILCOTT
MORRIS PLAINS, N.J.

Anusol-HC®
dependable Anusol suppositories w/hydrocortisone

AH-HC03

News

E. Trussell and his colleagues at Columbia University worked two years on their report. In fact, even before they recently released it, the Governor of one state—New York—asked for and got a law changing existing machinery to resemble that called for by the report's proposals.

What would these proposals do? They'd put an element of compulsion into the planning of medical facilities on a community-wide basis. They'd do so by setting up this triple-deck structure:

1. On the bottom would be the utilization committee of each hospital. Its members would be drawn from the hospital's medical and administrative staffs.

2. In the middle would be the regional councils. Their members would be drawn from existing medical and hospital organizations, Blue Cross, industry, labor, and local health-and-welfare departments.

3. At the top would be the State Hospital Review and Planning Commission. At least half its members would be chosen by the regional councils. The rest would be chosen by the Governor of the state.

To start with, each hospital's utilization committee would send to its regional council reports on its use of services, standards of care, admissions, and length of stay. From these reports, every council would draw up a master plan to arrange for the most efficient use of its region's hospital facilities.

Suppose that a certain hospital then decided to add an obstetrical service and some obstetrical beds. Then suppose the council for that hospital ruled—on the basis of its reports—that the region already had enough such beds. The hospital could still go ahead and build them. But the new state commission mightn't approve of Blue Cross' paying benefits for their use.

Or again, suppose that a hospital reported abnormally high costs. And suppose that, after long discussion between the hospital and its regional council, these costs remained just as high. Then the council might—as a last resort—ask the state commission to pare down the rate of payment that hospital got from Blue Cross.

Such tactics are expected to slow down the rise in Blue Cross rates, but not to halt it altogether. Other suggestions made by the Trussell report are intended to improve the plans' quality of service. For example, the report suggests directly to all eight of New York State's Blue Cross plans that they:

Continued on page 60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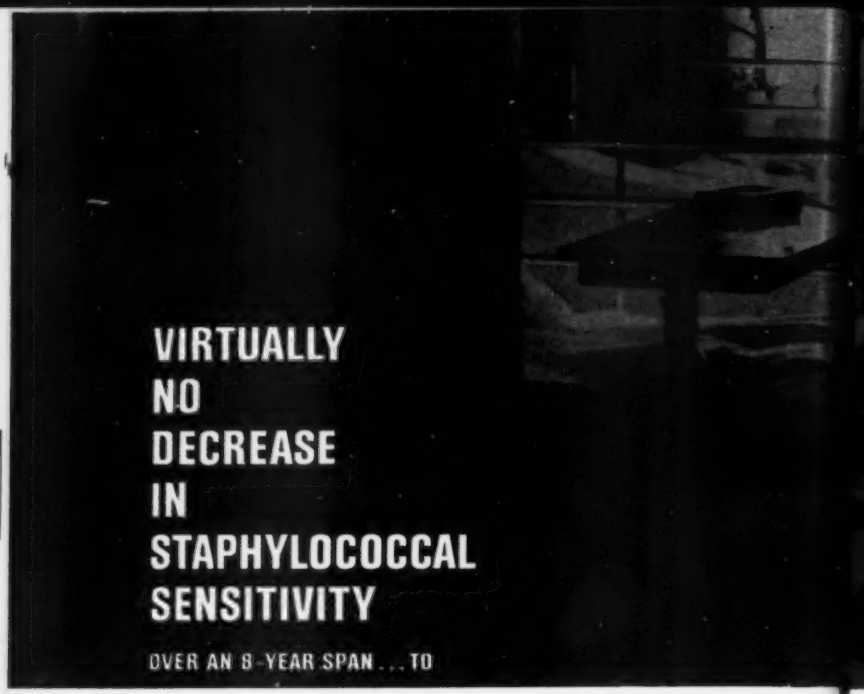


VIRTUALLY NO DECREASE IN STAPHYLOCOCCAL SENSITIVITY

OVER AN 8-YEAR SPAN . . . TO

CHLOROMYCETIN®

(chloramphenicol, Parke-Davis)

An outstanding and frequently reported characteristic of CHLOROMYCETIN[1-8] "...is the fact that the very great majority of the so-called resistant staphylococci are susceptible to its action."[1] In describing their study, Rebhan and Edwards[2] state that "...only a small percentage of strains have shown resistance..." to CHLOROMYCETIN, despite steadily increasing use of the drug over the years.

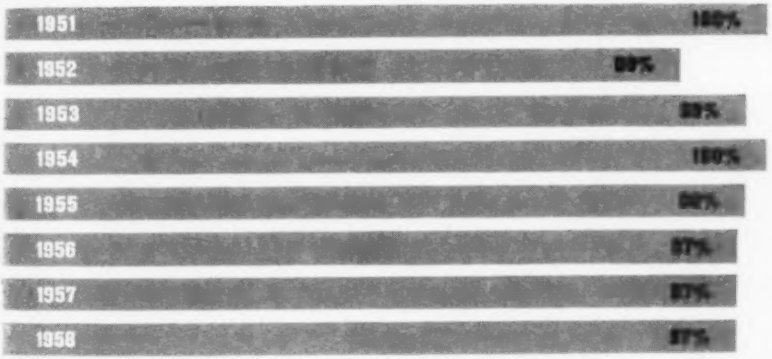
Fisher[3] observes: "The over-all average incidence of resistance, for the 31,779 strains [of staphylococci] through nine years was about 9%." Finland[4] reports that, while the proportion of strains resistant to several newer antibiotics has risen to between 10 and 30 per cent, such resistance to CHLOROMYCETIN "...has been rare even where this agent has been used extensively." Numerous other investigators concur in these findings.[5-8]

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals® of 250 mg., in bottles of 16 and 100.

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

References: (1) Welch, H., in Welch, H., & Finland, M.: Antibiotic Therapy for Staphylococcal Diseases, New York, Medical Encyclopedia, Inc., 1959, p. 1. (2) Rebhan, A. W., & Edwards, H. E.: *Canad. M. A. J.* **82**:513, 1960. (3) Fisher, M. W.: *Arch. Int. Med.* **103**:413, 1960. (4) Finland, M., in Welch, H., & Finland, M.: Antibiotic Therapy for Staphylococcal Diseases, New York, Medical Encyclopedia, Inc., 1959, p. 187. (5) Bercovitz, Z. T.: *Geriatrics* **15**:164, 1960. (6) Glas, W. W., & Britt, E. M.: Management of Hospital Injections, in Symposium on Antibacterial Therapy, Michigan & Wayne County Acad. Gen. Pract., Detroit, September 12, 1959, p. 7. (7) Staphylococcal Infections in Pediatrics, Scientific Exhibit, Commission on Professional and Hospital Activities, 108th Ann. Meet., A. M. A., Atlantic City, June 8-12, 1959. (8) Robinson, H. M., Jr.; Robinson, R. C. V., & Raskin, J.: *Postgrad. Med.* **27**:522, 1960.

IN VITRO SENSITIVITY OF PYOGENIC STRAINS OF STAPHYLOCOCCI TO CHLOROMYCETIN OVER A PERIOD OF EIGHT YEARS*



Statistics were gathered over almost a decade on 329 children with staphylococcal pneumonia; 1,663 sensitivity tests were performed

*Adapted from Bylsbaw & Edwards.[2]

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News

¶ Work toward a uniform basic contract that would give full coverage for 120 days.

¶ Experiment with coverage for out-patient diagnostic services such as lab tests and X-rays.

¶ Extend payments for post-hospital care in the home or in nursing institutions.

¶ Include mental health benefits and coverage of infants from birth (instead of from the age of ninety days).

¶ Get new blood on Blue Cross boards of directors by taking in representatives of industry, labor, public and private health and welfare agencies, and even some rank-and-file subscribers.

'Now's the Time to Borrow; The Credit Squeeze Is Off'

The nation's economy has settled down to a steady pace—not boom, but not bust, either. So now's the time to remodel the office or build a new home. This advice comes from syndicated Financial Writer Sylvia Porter. The credit picture has changed considerably from last fall, she points out.

Even this spring, money was scarce and borrowing costs had hit a peak. Then, a doctor with a building project was either turned down flat or offered loan terms that usually were too stiff for his pocketbook.

What will the doctor-borrower find now? In the first place, Miss Porter says, lenders aren't turning people away from their doors any more. The doctor who'll take time to shop around may even get a bargain.

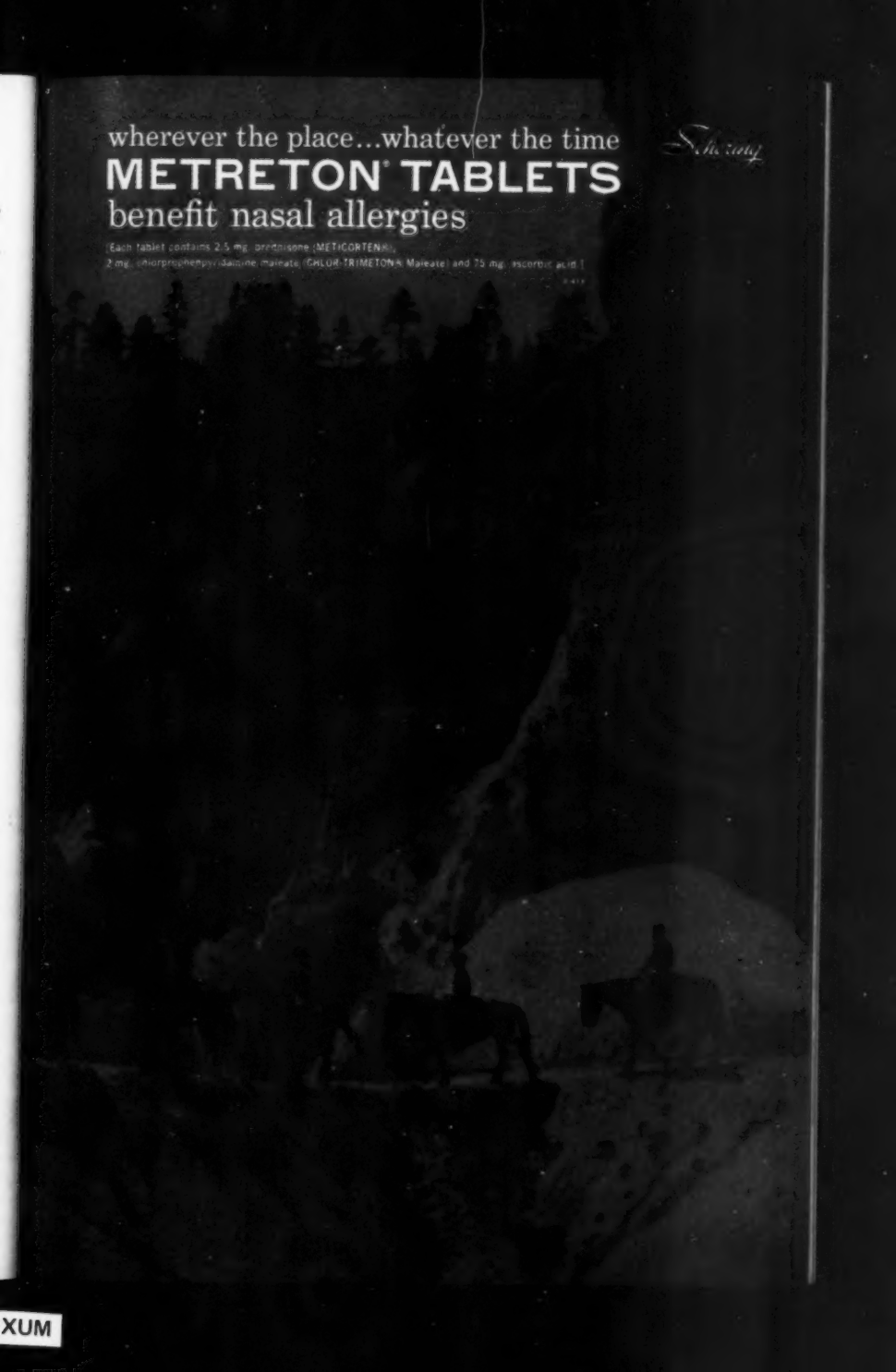
Secondly, not only is more mortgage money available, but interest rates are dropping slightly. Doctors in areas where the going mortgage rate has been 7 per cent may get 6½ per cent mortgages now. And in 6 per cent areas, loans are now being made at 5¾ per cent. What's more, a doctor who did get a loan during the recent credit squeeze may now be able to talk the lender into liberalizing the terms.

What has brought about this shift in the money picture? Sylvia Porter attributes it to three main factors:

1. Business isn't expanding. So corporations aren't scrambling for loans, and there's more cash available. A drop in home building has added even more to the money supply.

2. The U.S. Treasury isn't competing for loans. Last year the budget was way out of balance; so loans to the Government took up money that might otherwise have been available for loans to businessmen and home builders.

Continued on page 64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benefit nasal allergies
(Each tablet contains 2.5 mg. prednisone (METICORTEN®),
2 mg. chlorpropheniramine maleate (CHLOR-TRIMETON® Maleate) and 75 mg. ascorbic acid.)

the indication: **prostatitis**

the incidence: **"amazingly high"**—"Inflammations of the prostate gland... occur with an amazingly high incidence in general practice."

the inference: **probably "the most common chronic infection** in men over 40 years of age."

the ideal: "by far the most effective drug"

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". . . by far the most effective drug to be employed, and this has been substantiated in practice. It is a drug of low toxicity and, what is more important, bacteria rarely if ever become resistant to it. It can be employed for long periods of time, is bactericidal and does not favor the appearance of monilial infections."[3]

In acute prostatitis: "Antibacterial medication, preferably FURADANTIN (Eaton) 100 mg. 4 times daily is indicated . . ."[4]

In chronic prostatitis: "From clinical observation we have found that more cases of chronic prostatitis respond to FURADANTIN than to any other anti-infection agent."[5]

In benign prostatic hypertrophy: (to prevent or treat concomitant infection): "Nitrofurantoin [FURADANTIN] may be used for protracted periods for the suppression of infection in the urinary tract, even in the presence of probable obstruction . . . it may provide prolonged relief from symptoms and permit better selection of the proper time for surgical or manipulative procedures."[6]

Postoperatively in prostatic surgery: "In conjunction with routine post-operative care, FURADANTIN is frequently used."[7]

FURADANTIN ***dosage in prostatitis:*** Acute cases—100 mg. tablet q.i.d. with meals and with food or milk on retiring until cured. Chronic cases—100 mg. tablet q.i.d. for 10 to 14 days; depending on response, dosage may then be reduced to 100 or 200 mg. daily for 1 to 3 months.

Supplied: Tablets, 50 and 100 mg., Oral Suspension, 25 mg. per 5 cc. tsp.

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EATON LABORATORIES, NORWICH, NEW YORK

3. The Federal Reserve System has abandoned its tight money policy. This is a recognition, says Miss Porter, of the change in the economy away from "an inflation psychology."

Hospital With Staff D.O.s Can't Be Accredited Yet

If a hospital where M.D.s practice wants to add an osteopath to its staff, it may soon be able to do so with impunity. But if it takes on a D.O. right now, it may still automatically lose its accreditation.

That's what a county hospital in Kingwood, W. Va., was recently dismayed to learn. The hospital trustees knew that the American Hospital Association had decided recently to list institutions that have D.O.s on their staffs. The trustees also knew that the A.M.A. had recently told its representatives on the Joint Commission on Accreditation of Hospitals to consider "without prejudice" institutions that are required by law to admit D.O.s to their staffs.

Preston Memorial Hospital in Kingwood isn't required by law to admit D.O.s to its staff. But its nine staff M.D.s were filling only slightly more than one-third of its beds. So when the patients of a local osteopath clamored for the hospital to take him in, the trustees granted him six months' probationary staff privileges.

Soon the hospital got wind that it was about to lose its accreditation. To forestall such action, it quickly called Dr. Kenneth B. Babcock of the Joint Commission. Too late, he replied: The minute a D.O. started using the hospital, accreditation had been automatically dropped.

In that case, it was "impractical" for M.D.s to use the hospital any longer, declared the medical staff. So they threatened to quit.

What could the trustees do to prevent this? They withdrew the D.O.'s privileges. But he promptly got a three-month court injunction permitting him to hold onto his privileges while a judge studied the situation.

Finally the judge decided in favor of the trustees. They'd been within their legal rights in withdrawing the D.O.'s privileges, he ruled, since (1) the hospital had lost its accreditation because of him, and (2) the hospital was threatened with the loss of the rest of its staff.

So the osteopath was banished. But it won't be easy for the hospital to get back its accreditation. A new Joint Commission survey will be required before the institution can finally be sure of becoming accredited again. END

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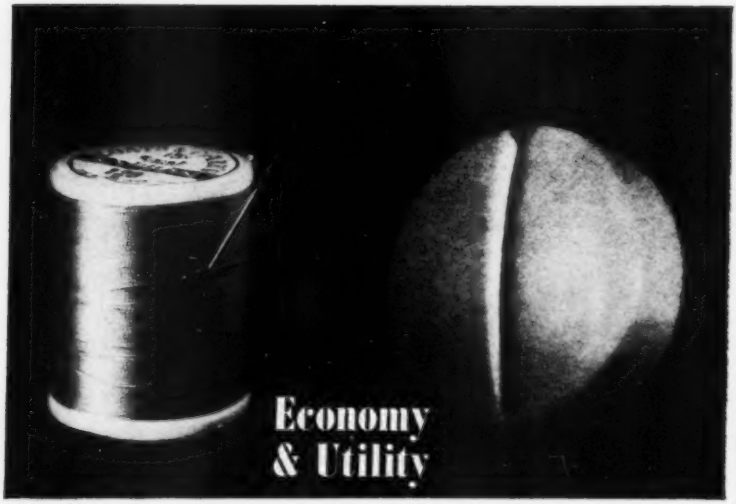

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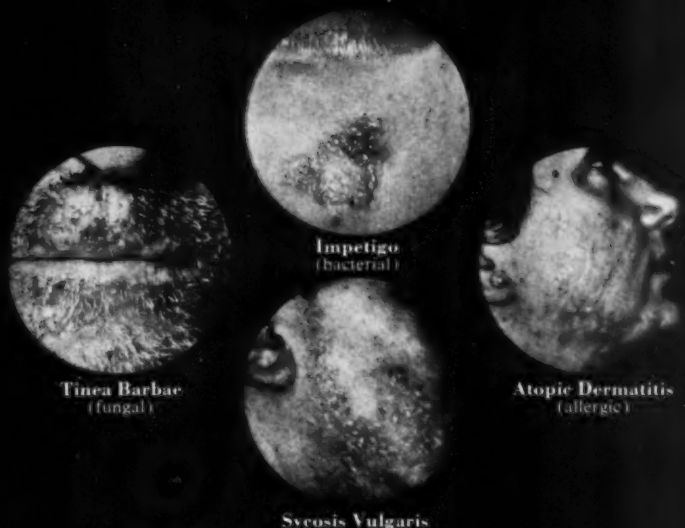

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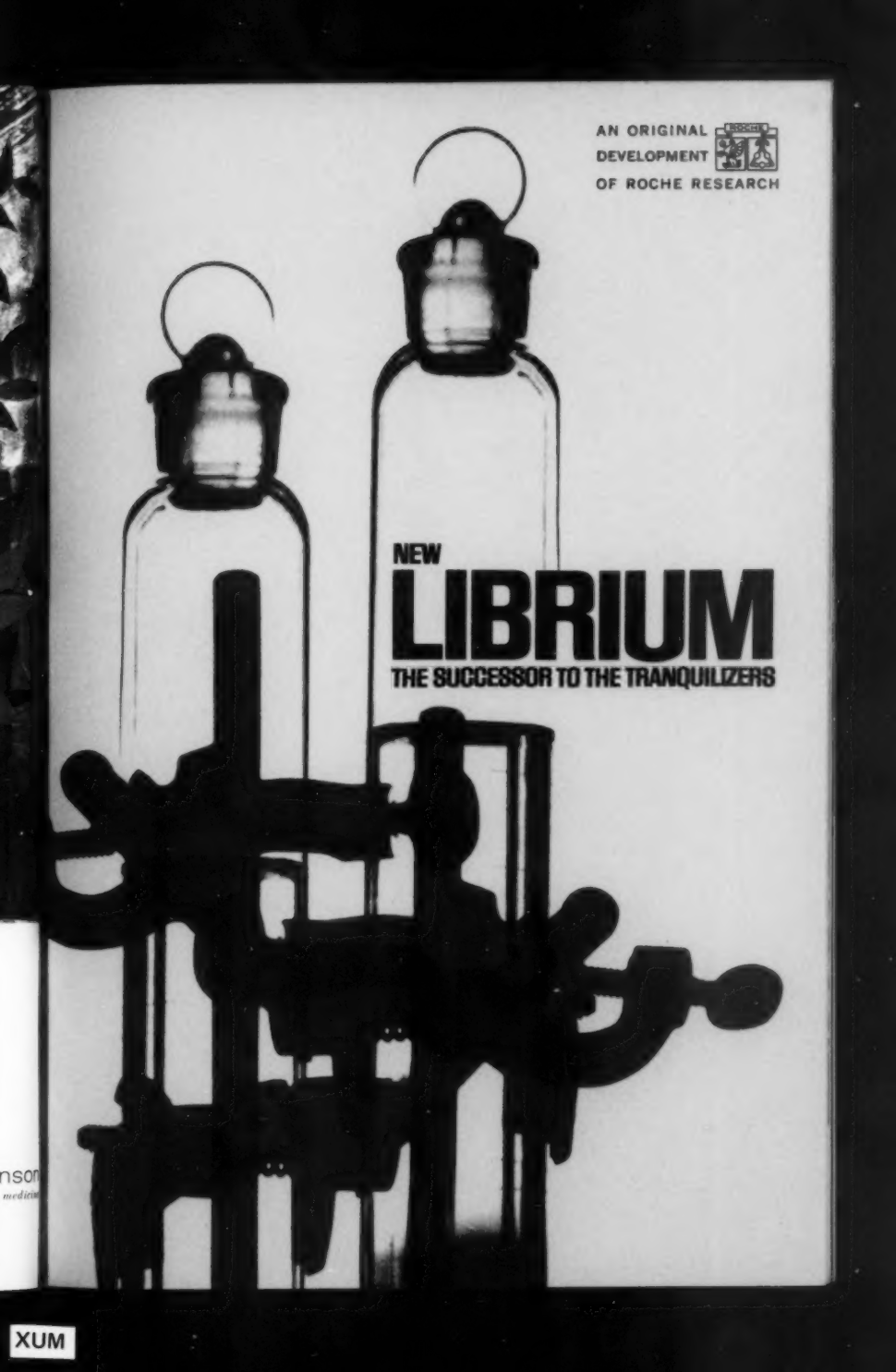
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The Librium Bibliography 1. T. H. Harris, *Dis. Nerv. System*, *21*: (Suppl.), 3, 1960. 2. L. O. Randall, *ibid.*, p. 7. 3. J. M. Tobin, I. F. Bird and D. E. Boyle, *ibid.*, p. 11. 4. H. A. Bowes, *ibid.*, p. 20. 5. J. Kinross-Wright, I. M. Cohen and J. A. Knight, *ibid.*, p. 23. 6. H. H. Farb, *ibid.*, p. 27. 7. C. Breitner, *ibid.*, p. 31. 8. I. M. Cohen, Discussant, *ibid.*, p. 35. 9. G. A. Constant, *ibid.*, p. 37. 10. L. J. Thomas, *ibid.*, p. 40. 11. R. C. V. Robinson, *ibid.*, p. 43. 12. S. C. Kaim and I. N. Rosenstein, *ibid.*, p. 46. 13. H. E. Ticktin and J. D. Schultz, *ibid.*, p. 49. 14. J. N. Sussex, *ibid.*, p. 53. 15. I. N. Rosenstein, *ibid.*, p. 57. 16. D. C. English, *Curr. Therap. Res.*, 2:88, 1960. 17. T. H. Harris, *J.A.M.A.*, 172:1162, 1960. 18. G. L. Usdin, *J. Louisiana M. Soc.*, 112:142, 1960. 19. I. N. Rosenstein and C. W. Silverblatt, paper read at Pan American Medical Association, 35th Anniversary Congress, Mexico City, Mexico, May 2-11, 1960. 20. K. Rickels, *ibid.* 21. N. Toll, *Dis. Nerv. System*, 21:264, 1960.

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Medical Economics
INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, AUG. 1, 1960

Your Surest Source Of Extra Income: Better Collections!

Investing in securities isn't the only way for you to increase your income. You may have a 'special situation' right under your nose: a collection ratio that's ripe for a boost. Here's how one doctor cashed in on it

By Geoffrey Marks

If your favorite stock moves up from 90 to 91, and you own 200 shares, you'll make $200 overnight—if you sell the shares. But if you're grossing as little as $18,000 a year from your practice on a 90 per cent collection ratio, and you push that ratio up to 91, you'll also make $200. It will take you a year—but you *won't* have to sell your practice.

Lift the collection ratio to 95, and your year's profit will be $1,000. And, as an added attraction, you'll go on making that much year after year as long as you don't let the ratio slip back to the old level.

Like many physicians, you may be grossing closer to $36,000 than to a modest $18,000. In that case, five points on a 90

THE AUTHOR *is a partner in the firm of Management Associates, Spokane, Wash.*

per cent collection ratio would put you fully $2,000 ahead in a year—or $10,000 ahead in five years.

Here are the actual figures that proved my point to a client whom I'll call Dr. Deshler. He's a general practitioner in a medium-sized city in the Pacific Northwest. The following figures come from his daybooks for the years shown:

Rx for Healthy Accounts

There's more to the maintenance of a ledger account than the posting of debits and credits, says Management Consultant Geoffrey Marks. Twelve tips for the doctor's aide on how to keep accounts in good shape:

1. Date every entry *fully*.

2. When information on an account is received from the patient in person, enter it on the card *in his presence*.

3. If information comes in by mail or phone, summarize it promptly on the card, with the notation LTR or TEL. If a letter contains any hint of dissatisfaction with the care received, preserve it in the patient's chart; otherwise, destroy letters after summarizing them.

4. Conserve space by using abbreviations—e.g.: SAP (*Soon as possible*), WWC (*Will when can*), OOW (*Out of work*), WP 2-1 (*Will pay Feb. 1*), CSH (*Paid in cash*), CK (*Paid by check*), INS (*Paid by insurance*).

5. If a patient says he can't pay now, ask at once: "When do you think you'll be able to?"

6. Do all you can to get a promise of payment by a stated date.

¶ In the five-year period from 1950 through 1954, his total charges came to $201,950. He collected $181,750—90 per cent of the total.

¶ In the five-year period from 1955 through 1959, his total charges came to $225,100. He collected $213,850—95 per cent of the total.

So Dr. Deshler collected $32,100 more in the second five years

Enter that date on the card, and be sure the patient knows you're doing so.

7. When a patient makes a part payment, enter the balance due on his receipt, and give or send him the receipt.

8. Don't use collection stickers or rubber-stamp reminders. And don't write such remarks as "Overdue," "Please remit," etc., on your statements. What you have to say about an overdue account is worth saying by phone or letter.

9. When a statement comes back marked "Moved—No Address," etc., enter MR (*Mail return*) on the card at once. If a new address comes in *quickly*, re-mail; otherwise, send MRs to your collector right away.

10. The time to telephone about an account is between the second and third statement. Later calls generally bring empty promises.

11. Don't waste too much time on credit reports. "Commercial" credit and professional credit are different things. A leading credit bureau in the Northwest says: "An individual who pays everybody on time except his doctor gets an A-1 rating."

12. Watch out for the *active* delinquent: a patient who adds charges faster than he reduces the old bill. Press him for full payment every time you see him. If things don't improve, it may be wise to put him on a strict cash basis.

than he did in the first five. But that's not the most significant figure. What counts is the difference in his collection *ratio*—receipts as a percentage of charges. It jumped five points during the second period.

There are two ways of evaluating what this change did for the doctor. If his charges for the second period had exactly matched those for the earlier one, he'd have collected $10,102.50 *more* at the new ratio. Or, on the second period's charges with the old collection ratio, he'd have collected $11,260 *less* than he did. That's a pretty good pay-off for cleaning up your own backyard —which was all that Dr. Deshler had done.

For years, physicians have been asking me: "Can *I* rack up the 95 per cent collection ratio

"Yes, Professor Twiddle . . . but even if the specimen *is* authentic and King Tutankhamen *did* have pyelonephritis, where'll we find casts to prove it?"

you're always talking about? Do you really have clients whose credit losses amount to only 5 cents on the dollar?" My invariable answer: "Nine out of ten clients collect 95 per cent. They do it by *preventing* delinquency instead of merely trying to *correct* it."

When I first met Dr. Deshler back in 1955, he didn't feel too bad about his 90 per cent collection ratio. But when I came to look over the doctor's business methods, I realized that his 90 per cent was actually a tribute to the quality of his medicine and the loyalty of his patients.

A Twelve-Point Program

"It's a triumph of love over money," I said. Neither the doctor nor his aide had a real system for preventing accounts from becoming delinquent, nor for correcting delinquency when it occurred. Picking up an extra five points was a mere matter of introducing a twelve-point program that offended nobody.

The same program can do as much for you, if you're a Dr. Deshler. It breaks down into six rules for prevention and six for correction. Here are the six points of the prevention program that earned Dr. Deshler his $10,000:

1. Install adequate records. Dr. Deshler's records consisted of a ruled, legal-sized book (without columns) that served as a daybook, plus a supply of commercial-type ledger sheets filed in two post-binders. At my suggestion, he bought a columnar daybook and a supply of 4″ x 6″ ledger cards. (Last year, keeping up with the times, he switched to a 5½″ x 11½″ ledger card that is used in conjunction with a dry-heat copying machine.)

2. Keep the records right up to date. Only if records are fully current can they insure continuous observation of accounts with a tendency to delinquency. Dr. Deshler's record keeping used to fall down in two ways:

First, charges weren't entered promptly in the daybook. In theory, the doctor went over the book each evening and penciled in his charges. Actually, he often failed to do so.

Continued on page 182

How the Malpractice Threat Is Changing the Pra

It's making many doctors more careful, as this new nation-wide survey shows. In fact, it's making many ultra-cautious—so much so that one doctor in five thinks it's lowering the quality of care patients get

BY ROBERT L. BRENNER

An estimated 6,000 physicians in this country found themselves confronted with malpractice suits last year. Medico-legal experts put the total bill for these suits—counting attorneys' and witnesses' fees, court costs, and out-of-court settlements—at nearly $50,000,000.

Alarming statistics? Certainly. But perhaps even more alarming are comments of the type that two physicians recently made to MEDICAL ECONOMICS about the threat of malpractice litigation:

"In the things I say, in the things I do, in the things I write, and in the way I treat patients," a Tennessee orthopedic surgeon observed, "I now constantly feel the shadow of the plaintiffs' attorney lurking in my consultation room, in the operating room, and among my medical records."

And a California OB/Gyn. woman said bitterly, "I'm no

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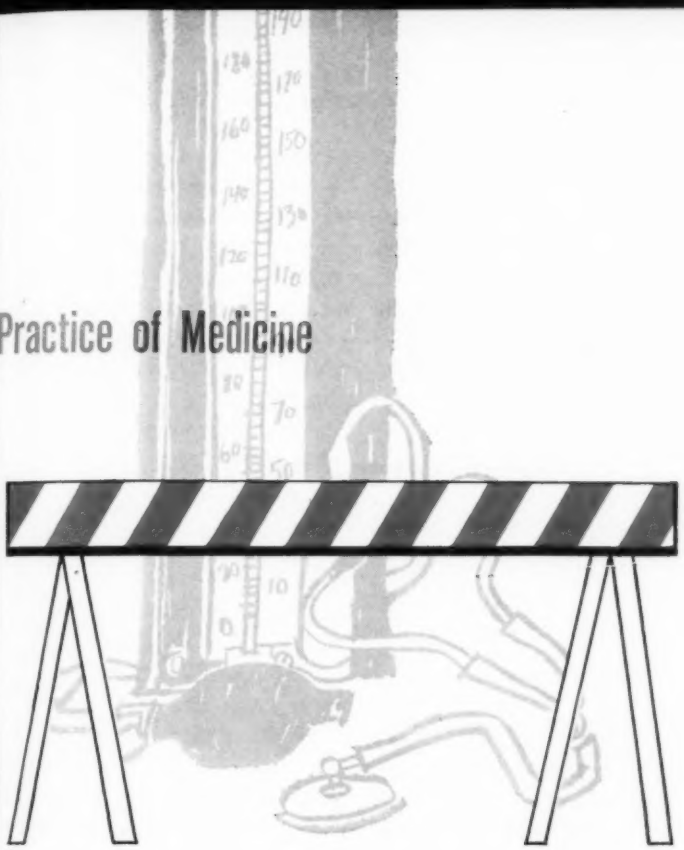
the Practice of Medicine



longer particularly proud to be a doctor, and I no longer enjoy my work. Because I've practiced ten years without a lawsuit, I feel sure that my number is nearly up. So I'm retiring at a very young age to a consultation practice. I'm quite glad to lay down the burden of a profession that has taken on the aspect of a game of one-upmanship with the potential litigant. The malpractice threat is at least half of my reason for retiring."

These two doctors' reactions are undoubtedly extreme. Even

so, the increasing likelihood of being sued hovers over most of America's practicing physicians. What key changes has it brought about? How widespread are they? And how do they affect the care that patients are getting?

MEDICAL ECONOMICS has just heard from more than 500 physicians on these and other questions related to the growing malpractice threat. Here, briefly, is their consensus:

¶ Many aspects of medical

How Their Practices Are Changing

The surveyed doctors were given a list of fifteen ways in which some physicians believe the public's suit-consciousness is changing the practice of medicine. They were asked whether any of these changes have occurred in their own practice. Here's the percentage of respondents that checked each item:

Change	% Citing It
I keep more detailed office records	54%
I keep more detailed hospital records	51
I order more X-rays	47
I use more consultations	43
I give less telephone advice	40
I order more diagnostic tests	37
I permit fewer Rx refills	36
I get more consent forms signed	30
I'm more selective about trying certain procedures	28
I refer more cases for treatment	26
I screen new patients more carefully for legal reasons	25
I hospitalize more patients	20
I follow manufacturers' recommended drug dosages more closely	16
I screen new patients more carefully for medical reasons	9
I keep patients hospitalized longer	7

practice are being altered by the pressure of potential lawsuits. Among the changes that doctors cite most often: They're keeping more detailed records; they're using more consultations; and they're ordering more X-rays and other diagnostic tests. Less frequently—but perhaps more seriously—doctors say they're becoming highly selective about the procedures they'll attempt.

Effects of Changes

¶ The economic effect of these changes is to make medical care more costly.

¶ The effect on quality is in dispute. Only one doctor in five says the malpractice threat is making him practice bad medicine. Of the rest, about half say the quality of care is unchanged; the others say it has improved.

These findings were arrived at as follows:

Doctors were given a list of fifteen common aspects of medical practice that some medical men have said are being affected by the increase in malpractice suits. The surveyed doctors were then asked whether their own practices are being changed in any of the ways listed. In addition, they were asked to describe (with case histories) any other ways in which their practices have changed. And, finally, doctors were asked what net effect they think such changes have had on patients' welfare.

The Major Changes

This article, the first of three based on this new study, describes in detail the ways in which physicians say their practices are being changed by the growing incidence of malpractice suits. As the table at the left shows, there are five common aspects of practice that 40 per cent or more of the doctor-respondents agree are being changed by the increase in lawsuits. These doctors now keep more detailed records on both hospital and office patients. They order more X-rays. They refer more patients for consultation. And they give less advice to patients by telephone.

But all this apparently varies with field of practice. G.P.s, for instance, say that ordering more

How It Affects the Different Fields of Practice

The effect that the growing danger of lawsuits has on a man's practice varies slightly with the field he's in, the new survey indicates. This table shows the five most common changes as reported by G.P.s, by internists, and by surgeons.

G.P.s

Change	% of G.P.s Citing It
I order more X-rays	64%
I keep more detailed office records	60
I use more consultations	55
I give less telephone advice	53
I permit fewer Rx refills	51

INTERNISTS

Change	% of Internists Citing It
I keep more detailed office records	57%
I keep more detailed hospital records	49
I permit fewer Rx refills	47
I order more X-rays	43
I use more consultations	40
I give less telephone advice	

SURGEONS

Change	% of Surgeons Citing It
I keep more detailed office records	61%
I keep more detailed hospital records	54
I order more X-rays	47
I get more consent forms signed	42
I use more consultations	40

X-rays is the most common change in their field; internists and surgeons cite this effect less often. And surgeons, as might be expected, list using more consent forms among their five most common changes; G.P.s and internists put this change further down on the list. The table on the facing page shows other variations by field of practice.

On Telephone Advice

More revealing than these statistics, however, are doctors' comments about some of the changes on the list. Take the subject of giving telephone advice to patients:

"I still give phone advice," says a California OB/Gyn. man, "but I've started making detailed notes of everything I say and everything the patient says on every call." And a Texas pediatrician adds: "I now record nearly all telephone conversations with parents, and I have them transcribed in red on my office records."

Or take the subject of ordering more diagnostic tests:

"In my first few years in practice, I squirmed whenever I ordered extra X-rays or diagnostic work, thinking of their effect on the patient's pocketbook," a Texas G.P. reports. "Now I order any tests I think may prove useful, saying to myself, 'Hang the expense!' "

On the same subject, a New York internist reports: "If a patient can't afford some test that I think might be helpful, I now refer him to a clinic to have it done rather than proceed on the basis of what may be an inadequate work-up." And a Pennsylvania surgeon comments candidly:

'They May as Well Pay'

"If a patient—or even one of his relatives—wants unnecessary X-rays or any other tests within reason, I no longer try to talk him out of it. I figure the public may as well pay for the high standard it demands of me, and for the trouble I must take to protect myself while rendering care."

Along these same lines, an Oklahoma surgeon reports that his use of more diagnostic work

has changed his whole philosophy of practice: "I find I tend to rely more on what X-rays and lab reports show than on what I see, feel, and know about a patient," he says. "This habit also leads me to doubt anything a colleague tells me that's not documented by a lab report, an X-ray, or a specimen."

Caution: New Patient

Here are some typical comments on the subject of screening new patients:

"I don't accept new patients who seem querulous or dubious about my ability," a California OB/Gyn. man says. "I keep in mind that no doctor has to accept a patient just because she comes to the office. (Many patients can't believe that merely walking through my door doesn't oblige me to accept them as patients.)"

"The growing number of suits has unquestionably made me more careful of what patients I'll accept," a Massachusetts surgeon says. "This is a precaution that many busy surgeons—and nearly all 'hungry' ones—overlook. They're just asking for trouble."

A Maryland anesthesiologist says frankly: "I don't like to deny my services to anyone who is sick. But if I think a patient is likely to sue me despite my best effort, I will refuse his case."

And a colleague concurs: "I'm one of a very few anesthesiologists in a sparsely populated Western state," he reports. "I used to be ready and willing to hop into a plane and fly hundreds of miles to help care for a patient too ill or too severely injured to be moved. Now I hesitate to take the responsibility for anesthetizing such patients when I have no control over their follow-up care."

More Consultations

Here are typical comments on the subject of using more consultations:

"I recently ordered a needless consultation for a child with a fever of undetermined origin solely because the parents seemed restless about the course of his illness," a Maryland pediatrician reports. "I'd have spared them

this expense if it wasn't for the malpractice problem."

"I used to handle nearly all my own cases, come what may," a Pennsylvania G.P. says. "But since lawsuits have become so commonplace, I've begun referring many more of them for consultation or treatment. I don't want to have to defend my methods of therapy before a lay jury."

And a Pennsylvania EENT man says: "Although I'm trained in rhinoplastic procedures, I now refer all such cases for consultation, and many of them for treatment. I do it simply to avoid possible postoperative litigation."

Finally, here's what doctors say about the procedures they're now willing to attempt:

"I won't try any procedure that's not generally accepted as the specific treatment for that specific condition, even though

Continued on page 192

"Are you sure it's bat wings and lizard legs, and not just a placebo?"

Busiest Solo Practice I've Ever Seen

You may never treat 125 patients a day, but here are some management tips from a man who does. He charges by the year, has fifteen aides and more leisure time than most M.D.s

By Horace Cotton

Often, in my years as a management consultant, I've nodded in silent sympathy when a physician-client has muttered: "I need a partner! This practice leaves me hardly a minute to call my own. The pace is killing me."

Recently, though, I met a physician who personally treats up to 125 patients in a single day. He doesn't need or want a partner. And when I asked him whether the pace wasn't too much for him, he replied: "But I have almost *unlimited* leisure. I see patients only three days a week."

Right then and there, I decided that this man's practice must be worth studying. And, through his courtesy, I have studied it. I spent ten hours taking notes, so that if you, too, ever want to set yourself up to handle 375 appointments on Tuesdays through Thursdays, you can discover from this article how one man manages it—with time to spare.

The man is a British-born internist-allergist, Ethan Allan Brown. Back in the 1930s, he was a staff member of Boston's Lahey Clinic. Three years was enough to convince him that he

was no organization man, but an organizer. He resigned from the group, bought a five-story building on Boston's Bay State Road, and began breaking with tradition in several ways at once.

Perhaps his boldest breaks were with clinical tradition. Here, as a management man, I can only report what I'm told. Dr. Brown began supplying allergic patients with individual doses of extracts, to be injected on set dates by their personal physicians. Finally he himself began giving massive injections, the effects of which were intended to last all of any one season, in lieu of the regular doses by family doctors. He has now given about 12,000 of these one-shot treatments. They have proved safe and effective, says Dr. Brown. But some of his Bos-

FIFTEEN FULL-TIME AIDES, *including the twelve shown here, work for Dr. Ethan Allan Brown (top).*

CHECKING OVER *each patient's chart prior to treating him is an invariable rule in Dr. Brown's office.*

BEFORE MILKMEN STIR, *Dr. Brown is usually at work in his study.*

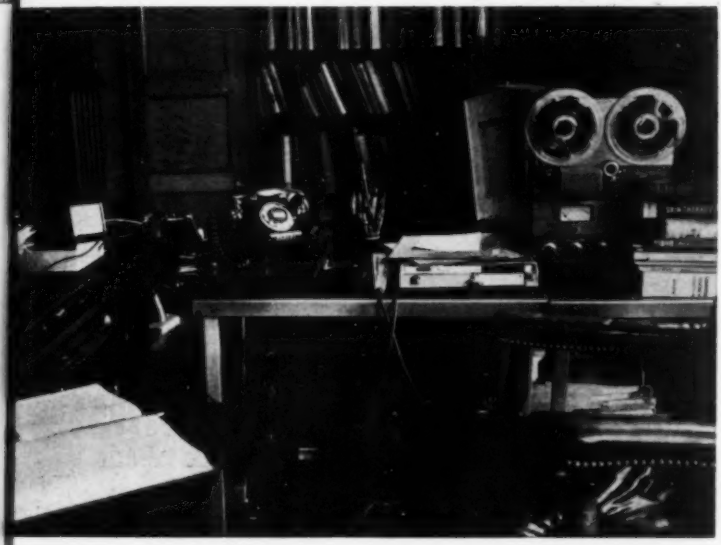
ton colleagues say otherwise. "Mildly irregular" and "playing with fire" are among the descriptive terms they use.

Still, Dr. Brown is no maverick. He's regularly invited to speak before professional societies (the latest: New York Allergy Society, Florida Allergy Society, American Academy of General Practice). He has published some 200 papers in medical journals here and abroad. Referrals come from fully 600 physicians located in every state in the union. And he has 6,000 cur-

rent case histories in a revolving file in his front office, with thousands more on his record-room shelves.

How can one man manage a practice of that size? By breaking a few more traditions. Dr. Brown uses more help than any other solo practitioner I've ever met. He employs six technicians, five secretaries, two receptionists, one office manager, and one bookkeeper—a formidable force.

"Not one of these fifteen girls has an I.Q. below 125," Dr. Brown told me. "I believe in finding the best and paying them well." But he doesn't pay anything to the best of them. "Helen earns two more salaries but doesn't get them," he says. Helen is Mrs. Brown, a skilled technician who supervises the laboratories at Bay State Road and watches over the myriad mundane purchases needed in such a



A VOICE-ACTIVATED MICROPHONE *operates one of Dr. Brown's eight audio devices. Recorded talks with patients can be played back at any time.*

ROTATING SHELVES *arranged in circular tiers hold patients' charts. Color tabs indicate ailments.*

king-sized practice. (Where else does a one-doctor office buy toilet tissues by the half-million sheets for five lavatories?)

Dr. Brown not only has a lot of help, he has it highly organized. Observe, as I did, how fifty-six patients were handled in three hours during one afternoon of a typical treatment day:

In a fair-sized room on the second floor at Bay State Road, eleven white cubicles form a hollow square. Looking through the open door from the landing outside the room, I could see that a patient sat in each cubicle. A technician was helping the patients prepare for their treatments. Meanwhile, outside the room, a small procession formed.

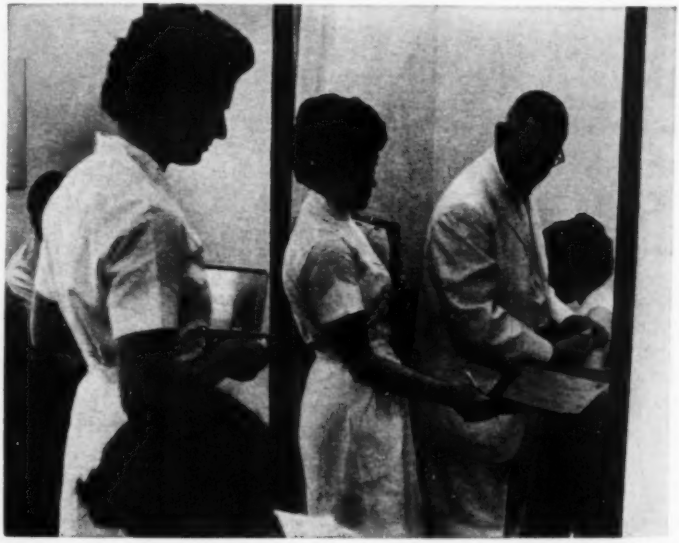
At its head was a technician bearing a trayful of labeled syringes charged with multicolored fluids. "Disposable syringes with disposable needles," Dr. Brown told me. "The time of these girls is too valuable to be spent on dishwashing. And for the highly individualized preparations that our patients need, it's best not to reuse syringes or needles."

Dr. Brown came second in the procession. He had earlier refreshed his memory by re-reading each of the patient's histories. Their charts were now carried on a clipboard by a technician who came third in line. She held a ballpoint pen at the ready. I wedged myself in the procession, shoulder to shoulder with Dr. Brown.

"Hello, Mr. Nelson," said Dr. Brown to the first patient he reached. "Hi, Doctor," said the man. Dr. Brown took the syringe held out toward him, glanced at the chart held up for inspection, and asked half a dozen questions. As he and the patient talked, Dr. Brown gave him three injections in quick succession. He dictated notes that were immediately written on the patient's chart. Mr. Nelson buttoned his shirt-cuff and put on his jacket.

There was no haste as Dr. Brown made his rounds. But in exactly fifteen minutes, all the cubicles were empty, and the aides busied themselves with making the arrangements for the next group.

Dr. Brown himself, I learned, gives all injections. He sees every patient at every visit. He dele-



DICTATING A CHART ENTRY *to one of his aides as he works, Dr. Brown gives an injection to an allergy patient, using a disposable syringe.*

DR. BROWN'S BASEMENT LABORATORY *has all the apparatus needed to prepare injectables, including an emulsifier he invented in his spare time.*

gates everything except the actual practice of medicine.

How is everything done so efficiently? Advance preparation is the answer. A day-sheet is prepared two days ahead. It lists each patient's name and the purpose of his visit. All the time-consuming work—pulling charts, scanning them, setting out supplies, charging syringes—is done before the patients arrive. The actual handling of patients is thought out so carefully that there's no waste motion. And if a patient needs more time to talk, he is taken into Dr. Brown's consultation room. There the discussion is recorded via a voice-activated microphone while the girls ready the next group of patients.

New patients, of course, get entirely different handling. Consider the case of a 70-year-old

patient who, it turned out, was suffering from senile emphysema. He walked in the front door of Dr. Brown's building at 2 P.M. Immediately a history was taken; blood samples and a urine specimen were obtained. Then the patient was put in a taxi and sent to the office of a near-by radiologist for an immediate chest X-ray. The same taxi brought him back to Dr. Brown's office.

Next came skin tests, a complete physical examination (findings were dictated during the exam), and an electrocardiogram (done in duplicate—one for the referring physician). While the electrocardiogram was being read, the radiologist telephoned his wet-film report. The laboratory studies, too, had by this time been completed. Dr. Brown's report to the referring

HIS AIDES SPECIALIZE: *These three have the training they need to help Dr. Brown with correspondence, statistics, and professional papers.*

physician was dictated in the patient's presence, so that he could interrupt to ask for an explanation of what it said. The man left the office at 3:40 P.M., exactly 100 minutes after he'd entered. And he paid his bill on the way out.

How does Dr. Brown set his fees? Here, too, he breaks with tradition. "People pay me by the year to keep them free of symp-

How to Keep 600 Referring

How many specialists get out fifty or more letters to referring physicians the same day they see the patients? Dr. Ethan Allan Brown does, and with no strain. He has delegated most of the job to his secretaries and to two Auto-Typists, one a $900 and the other a $1,200 machine.

Each machine uses perforated paper rolls to "play" an electric typewriter, pianola style. The roll for one is punched to produce a series of fifty special paragraphs; these are keyed numerically to push buttons on the Auto-Typist. The roll for the other machine is punched to produce thirty form letters.

Dr. Brown dictates the key-numbers of the written material he wants, adding the specific data on the patient and his condition. The Auto-Typist types the "automated" portion of the letter at the rate of 150 words a minute, stopping when necessary for the secretary to fill in the patient's name, the diagnosis, the name of the medicine prescribed, etc.

This is the way it sounds when Dr. Brown dictates a letter by the key-number method:

"History number 8087. Dr. Junius Parbold, address as shown. Dear Junie. One, Mr. Harold John Everett. Two, ragweed pollen. Three, skin tests. Four, ragweed pollen emulsified. Five, photocopy. Six, my regards to your charming wife. We so enjoyed meeting you both in Miami."

The patient may take the signed letter away with him and hand

toms," he explains. "Since I switched to massive injections of emulsified extracts, one visit a year per allergen is enough for many patients. But one visit or forty, the fee is the same."

Depending on the type of case, a patient may be charged $50 to $90 for a symptom-free ragweed pollen season. The annual fee for a chronic asthmatic patient with perennial difficulties and associ-

Physicians Happy

it to his family doctor in Indiana the next day. It will read somewhat as follows:

"Dear Junie: Your patient, Mr. Harold John Everett, came to this office today. As you know, he has a long history of discomfort caused by allergy to ragweed pollen.

"His skin tests were positive with an intracutaneous test of 1000 P.N.U./ml. He received a preseasonal injection of ragweed pollen extract emulsified in Arlacel A and Drakeol. The enclosed photocopy gives you the results of the physical examination, the pulmonary function tests, and the other laboratory studies deemed necessary. You are familiar with my discussion of this in Annals of Allergy, 17:358 (May-June) 1959. A reprint is enclosed.

"I have asked him to see you if he experiences any symptoms of any degree or type, however mild or transient, and for whatever reason, during the pollen season. Should it be necessary for him to have any additional treatment, please telephone me at any time, but preferably not on a Tuesday, Wednesday, or Thursday excepting before 9 A.M. or between noon and 2 P.M. or after 4:30 P.M. These days, you will remember, are usually booked heavily, and during patient-hours I try to limit calls to those that are most important. But do remember that my secretary will always arrange for me to call you the moment I am free.

"My regards to your charming wife. We so enjoyed meeting you both in Miami."

ated disorders may range from $250 to $500. "Research patients" and referred patients of very modest means aren't charged anything.

I asked Dr. Brown why he scheduled only three "patient-days" per week. "It's the only practical way to make the treatment schedule sacred," he told me. "And it *has* to be sacred. People travel great distances to keep their appointments. Less than 25 per cent of my practice is local. Patients are referred from all fifty states plus Canada, Mexico, South America, Europe —even Africa. These people

He Gets Fast, Full Case Histories

Dr. Ethan Allan Brown's patients write their own case histories. And they can, if they wish, write them at home.

At the time an appointment is made, one or more questionnaires are mailed to the patient. How many depends on the nature of his ailment. The quiz for respiratory allergy asks 100 questions. The answers are given on the patient's time, not the doctor's.

Dr. Brown goes over the completed quiz forms before he interviews the patient. He queries answers that seem to need amplification. When the patient is shown in, Dr. Brown presses a foot-switch to activate a specially made recording device with an eight-hour-belt. Then he starts asking supplementary questions—and every answer becomes part of the patient's history in his own words.

Later, Dr. Brown may select from the recording a few key statements for transfer to the patient's chart. But almost never is a belt transcribed in full. "I had the machine made to save dictating and transcribing time, not to increase it," he says. "The belt is filed by date in my office. I can listen to it again at any time."

Free Ride for Faithful Patients

Here's a transcript of Horace Cotton's questions and Dr. Ethan Allan Brown's answers concerning some novel concessions to long-time patients:

Q. What's this Twenty-Year Club of yours I've heard about?

A. Just a name we have for it around the office. I've been practicing here twenty-five years. Some patients have been with me all that time. You get attached to people who are as loyal as that. So, when a patient completes his twentieth year with me, or retires and goes on Social Security, I offer to treat him without fee thereafter.

Q. You mean no charge at all? Not even for materials?

A. No charge whatsoever.

Q. For the rest of their lives?

A. For the rest of their lives or mine. I don't know exactly how many members the club has at present. I doubt that it will increase beyond reasonable bounds. After all, twenty or more years is a long time to stay with one physician.

don't travel thousands of miles to waste time in my reception room.

"Then, too, between 200 and 300 of my patients are physicians or members of physicians' families. During the last year, in fact, I've treated more than 100 allergists. *They* can't afford to waste hours because I'm behind schedule. So I treat patients only three days a week, prepare for them properly, and see them on time."

"From what you've told me," I said, "I figure that you spend twenty-four hours a week examining and treating patients. You spend another twelve hours a week supervising office, laboratory, and research activities on 'no treatment' days. You say you spend twenty more hours a week in the study of experimental find-

ings, the collation and interpretation of statistics, the writing and editing of your papers, and your editorial duties for six journals. That adds up to fifty-six hours a week. Where's the 'unlimited leisure' you mentioned when we first met?"

His Leisure Time

Dr. Brown leaned back and chuckled. "You're not going to believe this, but I have available thirty-five additional hours each week that many people don't know exist. I get up and go to work between 2:30 and 3:30 every morning."

He wasn't fooling. He regards the five hours before 7:30 or 8:30 A.M. as leisure time. This is when he reads, paints, plays, listens to music or language tapes, and works in the laboratory or on his inventions. How else could he speak six languages, paint not-bad pictures, play and hear good music, win prizes for photography, and patent thirty-eight (soon to be thirty-nine) inventions?

"To understand a patient," Dr. Brown says, "I have to do what the patient does. To understand an activity, I have to do it for myself. When I was younger, I used to spend one night in a newspaper pressroom, another in a bakery, a third in a police cruiser, and a fourth with a night watchman or a mail clerk. I've learned wood turning, metalworking, patternmaking, freehand and mechanical drawing. I've done every farm chore. I've lived in a monastery."

By this time, it was growing dark outside. The Charles River shimmered in the street lights. Dr. Brown uncurled himself and said: "Let's go upstairs and visit with Helen."

We ascended. Twenty minutes later, Mrs. Brown and I sat companionably over our drinks in the penthouse living room. From the kitchen came the sound of a voice raised in song.

"Isn't Dr. Brown coming in?" I asked.

"He'll be here shortly," said Mrs. Brown. "He said you must be tired from all this talking. And, since he didn't have anything else to do, he decided to cook dinner." END

New Light on Your Right To Collect Disability Payments

Whether or not you're entitled to benefit payments doesn't depend on the precise wording of your insurance policy. This recent Supreme Court decision may mean a better deal for doctors whose 'disability' is in question

By Leon Wasserman, LL.B.

Eight years ago, Dr. George Graves Dixon, then of New York City, was forced to give up his full-time surgical practice. Contact dermatitis on his hands had failed to respond to any kind of treatment. He could no longer do the surgical work for which he'd been trained.

He had a disability policy with the Pacific Mutual Life Insurance Company that insured him as a "physician and surgeon." So he naturally applied for benefits and began to collect. After a few payments, though, he took a post as director of professional services of the Veterans Administration Center at Fort Harrison, Mont. Since the position is earmarked for a licensed M.D., the insurance company ruled that Dr. Dixon could no longer be considered disabled.

This decision seemed to the doctor to make sense. So he signed a release, ending his disability payments. But when he told me what he'd done, I suspected he'd made a mistake. I've always contended that a doctor should never passively submit to an insurance

company's decision that he's ineligible for disability payments; first, I feel, he should make sure of his legal rights.

Their Word's Not Final

The companies almost invariably interpret their policies very literally, contrary to court decisions; and I don't think it's right that they should. For instance, Dr. Dixon had been practicing surgery exclusively since 1941. As his lawyer, I pointed out to him that, no matter what the policy called him, he'd been a *surgeon,* when he became disabled, that he was not able to practice *surgery* in his new post or any other post, and that he was therefore entitled to disability benefits.

This is an important point. It's one I believe all doctors should be aware of—just in case. Fortunately, the rest of Dr. Dixon's story, which has recently come to a happy conclusion, bears out the point.

When I advised him to sue for his rights, he took my advice. And the court found that he was indeed disabled. The release he'd signed was set aside. The insurance company thereupon took the case to the U.S. Court of Appeals. But this body upheld the lower court. Said the Court of Appeals, in upholding the earlier decision:

"If [a physician's] occupation has become that of a recognized specialist in surgery and he suffers from a physical impairment . . . resulting in the forced discontinuance of his practice, for all practical purposes there is total disability. He can no longer pursue his real occupation. Against this possibility he may seek insurance protection."

Supreme Court's Action

The company still wasn't satisfied. It again tried to appeal the decision—this time, to the U.S. Supreme Court. And now at last the case is over: Taking a stand in the disability insurance picture for the very first time, the nation's highest tribunal has refused to hear the appeal.

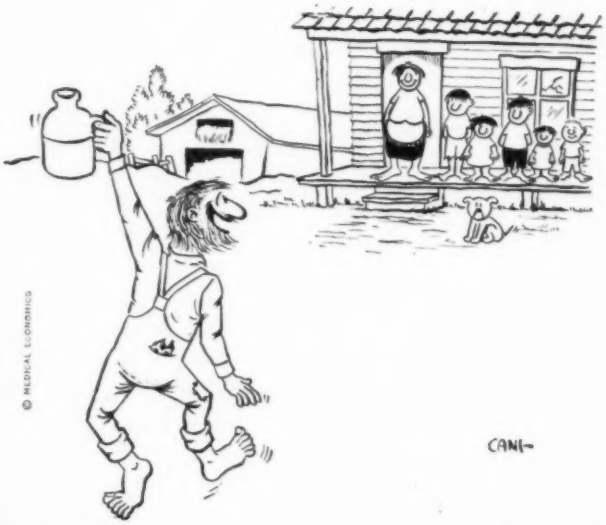
Why have the courts awarded $40,000 in back disability pay-

THE AUTHOR *is a member of the New York bar.*

ments and $400 per month for life to Dr. Dixon? Why have they done so even though his insurance contract required not only total disability "as a surgeon and physician," but also "total loss of business time"? Here's the answer, as I see it:

In general, the courts interpret the language of disability contracts in a *practical* rather than a *literal* way. For instance, your policy may state that you can't collect unless you're totally unable to do "each and every duty" pertaining to your occupation. But the courts have ruled that a disability to perform the *essential* duties will qualify a person for benefits under this clause.

Similarly, where a policy requires "total disability from pursuing *any* occupation," the courts have taken a liberal view of the meaning. They've ruled that "any



"Hi, Maw! The doc checked the specimen and we're all O.K.!"

occupation" means only any occupation *for which the insured is reasonably fitted by education and experience.*

A Sample Case

In one recent case, a middle-aged urologist's policy contained this latter proviso. After he'd had a heart attack, the company refused his claim for disability payments on the ground that he was still able to practice in a less demanding field of medicine. The court decided otherwise. It held that since the doctor's entire career had been in urology, he couldn't be expected to prepare himself for another field at that late date.

What sort of activity may you engage in under your disability policy without forfeiting your right to benefits? Chances are, your rights are much broader than you suspect. The new Supreme Court action makes that fact clearer than ever.

Even "strict confinement indoors"—a phrase that appears in many policies—has been legally interpreted to mean substantial *but not complete* confinement. In other words, if you are getting benefits under a disability policy that demands "strict confinement indoors," the company may not have the legal right to stop payments just because you go out now and then for a breath of air or to take a ride in a car.

The courts' rulings in such cases show how risky it is for any doctor to figure out his disability insurance rights on his own. Plain English and common sense aren't always trustworthy guides here. By relying on them, many a doctor who couldn't carry on his medical practice has wrongly believed he'd imperil his benefits if he earned his living in another way.

Get Other Advice

So if you should ever be so unfortunate as to become disabled, don't meekly accept the insurance company's word about your ineligibility for payments. In my opinion, no physician should ever complete a disability claims form without expert advice. He stands to lose too much. END

HELPING PREVENT IRON DEFICIENCY ANEMIA FOR A QUARTER OF A CENTURY: Baker's MODIFIED MILK

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1. Schulz, Jeannette & Smith, N.J.: A.M.A. J. Dis. Child. 95:109 (1958).
2. Josephs, H.W.: Medicine 32:125 (1953).

Can You Name These Doctors?

Millions of people who don't know that these are M.D.s do know their names. Do you? Here's the third in a series of quizzes about doctors famed for their nonmedical exploits

By James Joyce Donahue

Lots of doctors are well known for their accomplishments in medicine. But lots of others are even more famous for their achievements outside the medical field. Everybody remembers these men who made their marks throughout history. There were Writers Anton Chekhov, A. Conan Doyle, John Keats, Rabelais, Friedrich von Schiller, and Oliver Wendell Holmes. All of them were doctors. Among the signers of the Declaration of Independence was Dr. Benjamin Rush.

Among contemporary doctors who have achieved fame outside medicine are Novelist Frank G. Slaughter, Senator Ernest H. Gruening of Alaska, Poet William Carlos Williams, and Mountain Climber Charles S. Houston.

As in previous issues of MEDICAL ECONOMICS, you'll find in the following pages (106, 110, and 114) photographs and biographical sketches of three such physicians. Can you identify them? You'll find the right answers on page 139.

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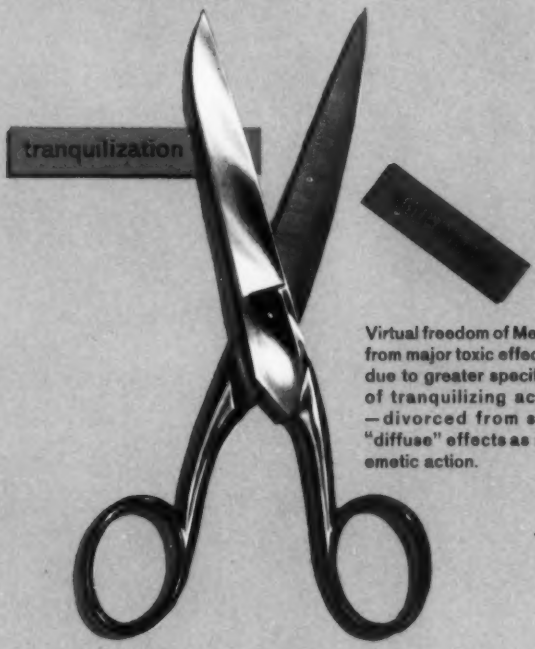

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"The most striking aspect of thioridazine [MELLARIL] therapy is the poverty of side-effects."

"In conclusion it may be said that thioridazine is at least as effective in relieving psychiatric illness as other drugs of its class. On a milligram for milligram basis it has the same order of potency as chlorpromazine. In its low incidence of side-effects and toxicity, it is superior to all other tranquilizing drugs tested. For this reason it is well tolerated by patients, particularly those who are not hospitalized and who frequently discontinue their medication with other drugs because of dizziness, sleepiness, increased tension, or Parkinsonism."*

Supply: MELLARIL Tablets, 10 mg., 25 mg., 100 mg.

SANDOZ

*Ginsss-Wright, J.: Newer phenothiazine drugs in treatment of nervous disorders, J.A.M.A. 170:1366, July 11, 1959.

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promptly relieves minor skin irritations

Summertime skin woes—poison ivy, insect bites, and sunburn—yield readily to the soothing effects of Lotion Surfadil. The anesthetic component stops pain and itch almost instantly. An odorless, skin-colored coating of antihistamine and adsorbent remains to maintain relief for hours.

This coating also helps *prevent* sunburn in your more sensitive patients. The ingredient titanium dioxide acts as a translucent "shield" to screen the sun's rays.

Each 100 cc. contain:

Histadyl™ . . .	2 Gm.
Surfacaine® . . .	0.5 Gm.
Titanium Dioxide	5 Gm.

Available in spillproof, unbreakable plastic containers of 75 cc.

Surfadil® (cyclomethycaine and thenylpyramine, Lilly)
Histadyl™ (thenylpyramine, Lilly)
Surfacaine® (cyclomethycaine, Lilly)

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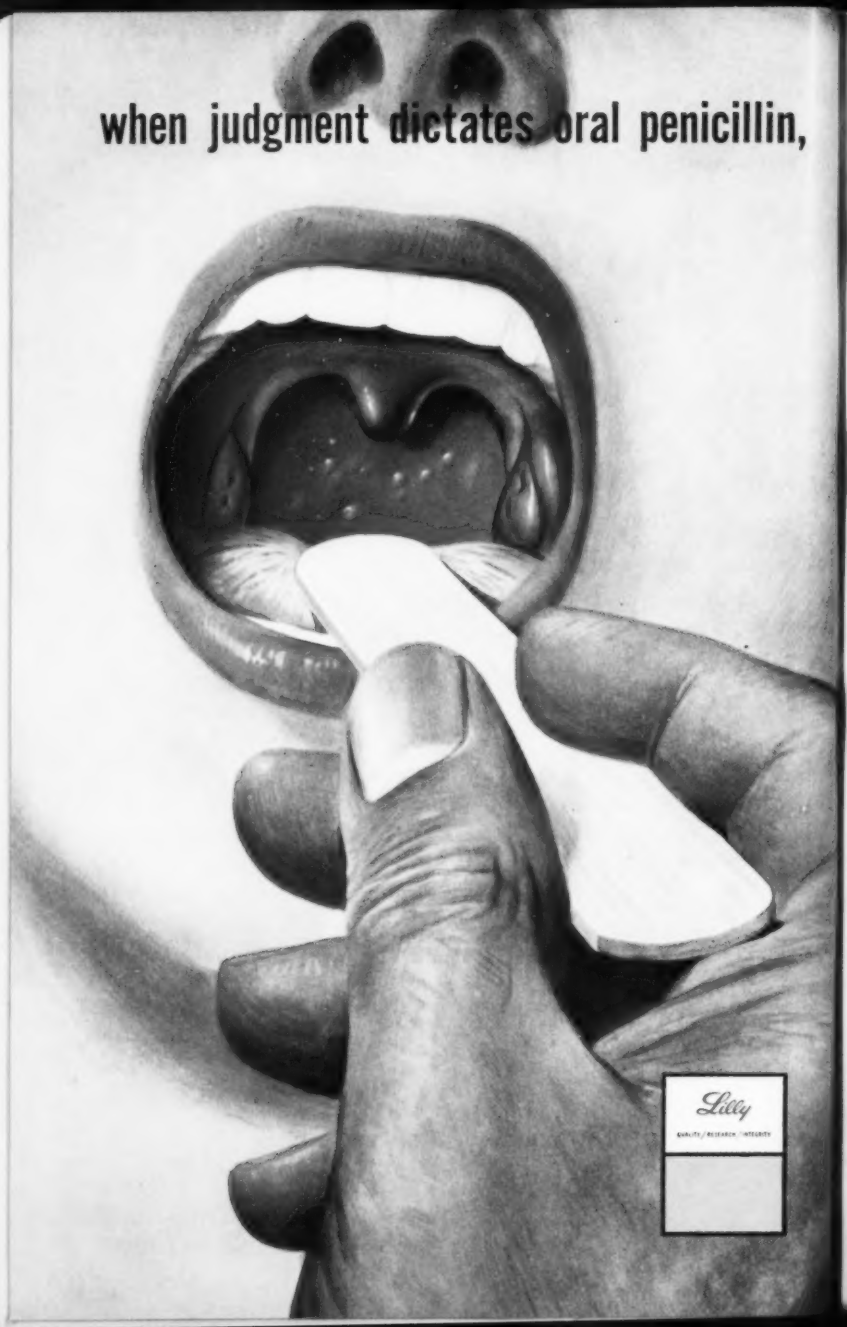
when judgment dictates oral penicillin,



experience dictates . . . . V-CILLIN K®

(penicillin V potassium, Lilly)

for maximum effectiveness

Recently, Griffith[1] reported that V-Cillin K produces antibacterial activity in the serum against penicillin-sensitive pathogens which is unsurpassed by any other form of oral penicillin. This helps explain why physicians have consistently found that V-Cillin K gives a dependable clinical response.

for unmatched speed

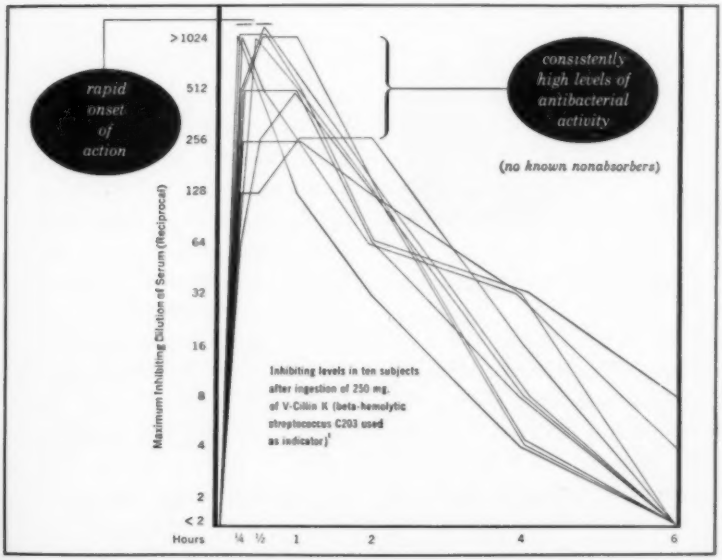
Peak levels of antibacterial activity are attained within fifteen to thirty minutes—faster than with any other oral penicillin.[1]

for unsurpassed safety

The excellent safety record of V-Cillin K is well established. There is no evidence available to show that any form of penicillin is less allergenic or less toxic than V-Cillin K.

Usual dosage: 125 or 250 mg. three times daily. Supplied as scored tablets of 125 and 250 mg.

1. Griffith, R. S.: Comparison of Antibiotic Activity in Sera Following the Administration of Three Different Penicillins, Antibiotic Med. & Clin. Therapy, 7: No. 2 (February), 1960.



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11753

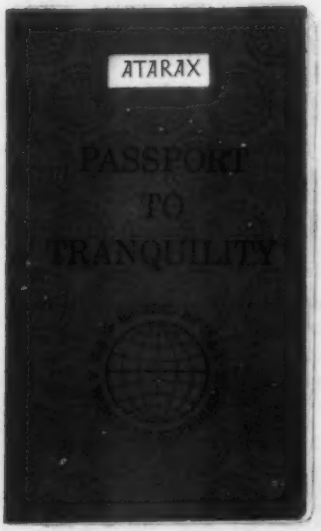
1. Athlete

The huge throng set up a chant, "C'mon, Golden Boy," as the young medical student stepped to the plate in the 1947 World Series. He responded by delivering a ringing double to keep a New York Yankee rally alive—and to set a record for pinch hits (three) in a Series. Two years later, this third baseman got six hits in twelve times at bat to tie another World Series record with a .500 batting average. In that same series, he smashed two triples to tie yet a third Series record—one that had stood since the great Eddie Collins set it in 1913. A tall, blonde, left-handed batter, the young ballplayer acquired the nickname "Golden Boy" when the Yanks gave him a $50,000 bonus to sign up with them. From 1946 until 1950, he divided his time between baseball and Tulane University, where he took his M.D.-degree. He played with the Yanks through 1954, with nearly two years (1952-53) out for Army duty. He now practices medicine in Fort Worth, Tex. You know who he is, don't you?

Continued on page 110

—A→ GUIDE TO

THE REALMS OF THERAPY BEST ATTAINED WITH



ATARAX quite consistently brings release from anxiety and tension without objectionable side effects. In addition, ATARAX has proved pre-eminent in certain therapeutic areas (briefly reviewed to the right)—areas that, to many doctors, are now clearly staked out as "ATARAX territory." Have you explored them all?

WORLD-WIDE RECORD OF EFFECTIVENESS—over 200 laboratory and clinical papers from 14 countries

WIDEST LATITUDE OF SAFETY AND FLEXIBILITY—no serious adverse clinical reaction ever documented

CHEMICALLY DISTINCT AMONG TRANQUILIZERS—not a phenothiazine or a meprobamate

ADDED FRONTIERS OF USEFULNESS—antihistaminic; mildly antiarrhythmic; does not stimulate gastric secretion

Special Advantages	Supportive Clinical Observation	. . . and for additional evidence
IN CHILDREN unusually safe; palatable syrup, 10 mg. tablet	". . . Atarax appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior. . . ." Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958.	Bayart, J.: Acta paediat. belg. 10:164, 1956. Ayd, F. J., Jr.: California Med. 87:75 (Aug.) 1957. Nathan, L. A., and Andelman, M. B.: Illinois M. J. 112:171 (Oct.) 1957.
IN ELDERLY PATIENTS well tolerated by debilitated patients	". . . seems to be the agent of choice in patients suffering from removal disorientation, confusion, conversion hysteria and other psychoneurotic conditions occurring in old age." Smigel, J. O., et al.: J. Am. Geriatrics Soc. 7:61 (Jan.) 1959.	Settel, E.: Am. Pract. & Digest Treat. 8:1584 (Oct.) 1957. Negri, F.: Minerva med. 48:607 (Feb. 21) 1957. Shalowitz, M.: Geriatrics 11: 312 (July) 1956.
IN ALLERGIC PATIENTS useful adjunctive therapy for asthma and dermatosis; particularly effective in urticaria	"All [asthmatic] patients reported greater calmness and were able to rest and sleep better . . . and led a more normal life. . . . In chronic and acute urticaria, however, hydroxyzine was effective as the sole medicament." Santos, I. M., and Unger, L.: Presented at 14th Annual Congress, American College of Allergists, Atlantic City, New Jersey, April 23-25, 1958.	Eisenberg, B. C.: J.A.M.A. 169:14 (Jan. 3) 1959. Coirault, R., et al.: Presse méd. 64:2239 (Dec. 26) 1956. Robinson, H. M., Jr., et al.: South. M. J. 50:1282 (Oct.) 1957.
IN HYPEREMOTIVE ADULTS does not impair mental acuity	". . . especially well-suited for ambulatory neurotics who must work, drive a car, or operate machinery." Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957.	Garber, R. C., Jr.: J. Florida M. A. 45:549 (Nov.) 1958. Menger, H. C.: New York J. Med. 58: 1684 (May 15) 1958. Farah, L.: Internat. Rec. Med. 169:379 (June) 1956.

ATARAX®

(brand of hydroxyzine)

Rx only

SUPPLIED: Tablets, 10 mg., 25 mg., 100 mg.; bottles of 100. Syrup (10 mg. per tsp.), pint bottles. Parenteral Solution, 25 mg./cc. in 10 cc. multiple-dose vials; 50 mg./cc. in 2 cc. ampules.

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Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being

2. Statesman

The biggest man in one of the biggest countries in the world, this statesman is the author of and driving force behind one of the most ambitious national undertakings in history. A man of vision, integrity, and intelligence, he has an abiding faith in his nation's people and resources. He has courted disaster, in the form of self-induced inflation, to push ahead with his gigantic project for harnessing his country's resources and for building great cities where there were none. If it pans out, he will go down as a national hero. The son of an immigrant Silesian farmer, he worked as a telegraph operator to send himself through medical school. He interned abroad and returned to his native land in 1929 to take a position as a police surgeon. He entered politics in 1934 as an elected member of his country's Chamber of Deputies. In 1955, he was elected to his nation's highest office, which he still holds. Who is he?

Continued on page 114

BELLERGAL®

SPACETABS®

effectively relieves distress of
hot flashes · sweating · headache
· excessive fatigability
· irritability · palpitation · insomnia

"A double blind study shows that... Bellergal Spacetabs is well suited for the symptomatic treatment of patients with vasomotor symptoms. Excellent to good results were achieved in 78 per cent of all complaints.... Symptoms of autonomic instability in patients with psychosomatic disorders alone, in those in the menopause, or in those in whom it was concomitant with organic disease were well controlled." Bernstein, A. and Simon, F.: Angiology 9:197, August 1958.

BELLERGAL SPACETABS— Bellafoline 0.2 mg., ergotamine tartrate 0.6 mg., phenobarbital 40.0 mg. *Dosage:* 1 in the morning, and 1 in the evening.

BELLERGAL TABLETS— Bellafoline 0.1 mg., ergotamine tartrate 0.3 mg., phenobarbital 20.0 mg. *Dosage:* 3 to 4 daily. In more resistant cases, dosage begins with 6 tablets daily and is slowly reduced.

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now–for more comprehensive control of

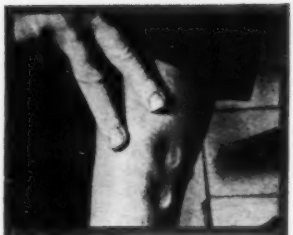
'pain & spasm'

INDICATIONS

HEAD: temporomandibular muscle spasm • NECK: muscular torticollis, osteoarthritis of cervical spine with spasm of cervical muscles, whiplash injury • TRUNK AND CHEST: costochondritis, intercostal myositis, xiphodynia • BACK: acute and chronic lumbar strains and sprains, acute low back pain (unspecified), acute lumbar arthritis and traumatic injury, compression fracture, herniated intervertebral disc, post-disc syndrome, strained muscle(s) • EXTREMITIES: acute hip injury with muscle spasm, ankle sprain, arthritis (as of foot or toe), blow to shin followed by muscle spasm, bursitis, spasm or strain of muscle or muscle group, old fracture with recurrent spasm, Pellegrini-Stieda disease, tenosynovitis with associated pain and spasm.

3. Actress

This remarkably versatile and beautiful flower of the Orient has achieved outstanding success in what is primarily a man's world: Japan. At 29, she has already tried her hand at three different careers—and has rated a "Banzai" for each of them. While still in Tokyo Women's Medical College, she wrote her first novel. A tender story of young love in postwar Japan, it was acclaimed by the critics. She had barely received her M.D. when in 1955 she was induced by a leading Tokyo film maker to audition for a movie role. She made such a hit that she was cast as heroine in a big production. The day after the première, she found herself the new toast of Japanese filmdom. Despite the attention she has received for her writing and acting, medicine remains her true love. As a practicing internist in Tokyo, she has been determinedly resisting all persuasion to have her devote more time to a screen career. Do you know her name? END



patient with congestive heart failure; ascites and 4+ edema to the knee

with Esidrix, 12½ pounds lost in 13 days; basilar râles and ascites no longer present; pitting edema cleared

Photos used with permission of the patient.

benefits in edema, benefits in hypertension plus added potassium protection

NEW ESIDRIX-K T.M.

New ESIDRIX-K provides all the oral diuretic-antihypertensive advantages of ESIDRIX, plus a properly proportioned potassium supplement. ESIDRIX produces marked excretion of salt and water in edematous patients, and in many hypertensive patients significantly reduces blood pressure, alone or with other antihypertensive drugs. Potassium excretion is minimal, and the built-in K supplement further helps eliminate problems due to potassium loss. Three ESIDRIX-K tablets provide potassium equivalent to one quart of fresh orange juice; ESIDRIX-K is coated to prevent gastric irritation.

Complete information sent on request.

Supplied: Esidrix-K Tablets (white, coated), each containing 25 mg. Esidrix and 500 mg. potassium chloride. Esidrix Tablets, 25 mg. (pink, scored), and 50 mg. (yellow, scored).

Esidrix-K is especially indicated for patients in whom even moderate potassium loss can cause complications, or those whose condition predisposes to hypokalemia. Among candidates for Esidrix-K are patients taking digitalis for congestive heart failure, those with renal or liver disease, those under long-term treatment, and those on salt-restricted diets.

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How You Get Paid for Treating Uncle Sam's Employes

Here's what you need to know about the country's newest and largest health insurance program, which probably covers more of your patients than you now suspect

BY LOIS R. CHEVALIER

If you haven't yet treated a patient who has the spanking-new health coverage available to Federal workers, chances are you soon will. Uncle Sam's gigantic program, launched July 1, covers 4,000,000 people—1,800,000 Federal employes and their dependents—scattered through almost every nook and cranny of the fifty states. And you probably have more such individuals among your patients than you realize.

The Government has given them—but not you—a pamphlet explaining their coverage. The explanation isn't easy to follow, even for U.S. employes who are accustomed to translating Federalese into English. So a good many of them may ask you to help them figure out their benefits. That's one good reason why you should know the score right now.

Another reason: Some observers believe that the new plan may well set nation-wide standards for adequate health coverage. It's the most nearly uniform national package for the largest

number of people yet. And though it contains no startling innovations, it's probably the first health insurance program to offer so many benefits to such a broad segment of the American public.

In essence, the subscriber has

How the Service Plan for

QUESTION: This patient, Harry Wilson, is a forest ranger. He makes $5,800 a year, is married, and has a family. He signed up for the high-option service plan. If he or any of his dependents finds it necessary to go into a hospital, what would his coverage provide?

ANSWER: *120 days of full coverage, semiprivate or ward.*

Full coverage for operating room, recovery room, drugs, dressings, lab work, X-ray, and anesthesia.

*Your Blue Shield's scheduled fees for medical and surgical services, including hospital visits for medical cases.**

QUESTION: What does the coverage provide if a member of the Wilson family should have a catastrophic illness?

ANSWER: *After basic Blue-plan benefits are exhausted, Harry Wilson must pay the next $100 of medical expenses. The plan picks up 80 per cent of the usual charges for further hospital and doctor bills, up to a total of $20,000 for the twelve-month benefit period.*

QUESTION: What does the plan pay for a nonhospitalized patient?

ANSWER: *Whatever your Blue Shield pays for out-of-hospital services (e.g., office surgery).*

*The fee schedule used is your plan's top-grade medical and surgical contract—the one with family income limits of $6,000 or more. For a single subscriber, the income ceiling is $4,000. If your Blue Shield is an indemnity plan, however, you aren't required to give service coverage.

a choice between a commercial indemnity plan (which pays the patient) and what the Government calls a service plan (Blue Cross-Blue Shield). If he chooses the service plan, he gets basic Blue coverage plus supplemen-

Continued on page 122

Federal Employes Works

After Harry Wilson has paid $100 out-of-pocket for any one member of the family, that person gets coverage for office visits, house calls, out-patient lab work, and diagnostic or therapeutic X-ray.

The coverage reimburses Harry Wilson for 80 per cent of your usual fees. You bill him for the total amount.

QUESTION: What about other expenses?

ANSWER: *Special nurses, prescription drugs, physiotherapy, braces, crutches, and artificial limbs and eyes are covered on the 80 per cent basis, in or out of hospital, after the deductible has been paid.*

QUESTION: What maternity coverage does the program offer?

ANSWER: *The hospital bill is covered, up to $100.*

The obstetrician's and the anesthesiologist's fees are paid according to the Blue Shield schedule.

QUESTION: Is coverage provided in case of mental or nervous disorders?

ANSWER: *In-patient care in a mental hospital is covered on the $100-deductible, 80 per cent basis.*

Out-patient treatment is covered on a $100-deductible, 50 per cent basis.

Your surgical convalescent
feels better
because he is better
with

Durabo

tary major medical benefits. If he chooses the commercial indemnity plan, he pays a small deductible; and there's also a co-insurance factor. Under this latter plan, of course, you charge your usual fees. (In some areas, the employe has a third choice: He

How the Indemnity Plan for

QUESTION: This patient, Violet Hollister, is a secretary. Her husband and two children are covered by her insurance. The Hollisters chose the high-option indemnity plan. If any member of the family is hospitalized, what does the coverage provide?

ANSWER: *Full coverage in semiprivate or ward accommodations, up to a $1,000 limit in any calendar year. Coverage for 80 per cent of the room and board charges over $1,000. Partial coverage for doctor bills, operating room charges, drugs, dressings, lab work, X-ray, and anesthesia. After the Hollisters pay a $50 deductible for any member of the family, the plan meets 80 per cent of all that person's bills during the current year.**

QUESTION: What does the coverage provide if a member of the family has a catastrophic illness?

ANSWER: *Once the blanket $50 deductible has been satisfied, the plan will pay up to $30,000 toward any one person's medical and hospital expenses.*

QUESTION: What does the plan pay for nonhospitalized patients?

ANSWER: *Coverage for 80 per cent of all doctor bills beyond the $50 deductible. This includes your usual fees for office surgery, house calls, office visits (exclusive of routine physicals, refractions,*

*Note, however, that the Civil Service Commission states: "This plan does not provide benefits for services and supplies to the extent that they are overpriced."

may join up with a closed-panel plan or some other special plan that meets the specifications.)

The average patient stands to get fairly substantial help for whatever medical problem he encounters, no matter which type of plan he selects. Once he has

Federal Employes Works

and immunizations), diagnostic and therapeutic X-ray, lab work, ECGs, etc.

Prescription drugs for nonhospitalized patients are covered on the 80 per cent basis after the person has paid the first $30 out-of-pocket in any calendar year.

QUESTION: What does the plan pay for other expenses?

ANSWER: *Special nurses, physiotherapy, and artificial limbs and eyes are 80 per cent covered, whether the patient is in or out of the hospital.*

QUESTION: And if Mrs. Hollister has a baby?

ANSWER: *She'll get $15 a day in the hospital for a maximum of ten days. She'll also get $90 for the obstetrician and $18 for the anesthetist for a normal delivery; or $150 for the obstetrician and $30 for the anesthetist for a Caesarean section. There's no deductible on maternity benefits.*

Maternity benefits are indemnities for the patient. Doctors may bill their usual charges, of course.

QUESTION: Is there coverage for mental or nervous disorders?

ANSWER: *Care in a mental hospital is provided on the same basis as care in any other hospital. Out-patient treatment is 50 per cent covered, after the $50 deductible is paid.*

met a portion of his expenses out of his own pocket, he has coverage toward office visits, house calls, drugs, special nurses, and physiotherapy. The insurance covers the newborn. There's no waiting period for maternity benefits. There's help for nervous and mental disorders. And the Government worker does not lose his health insurance coverage when he retires.

High Benefits Preferred

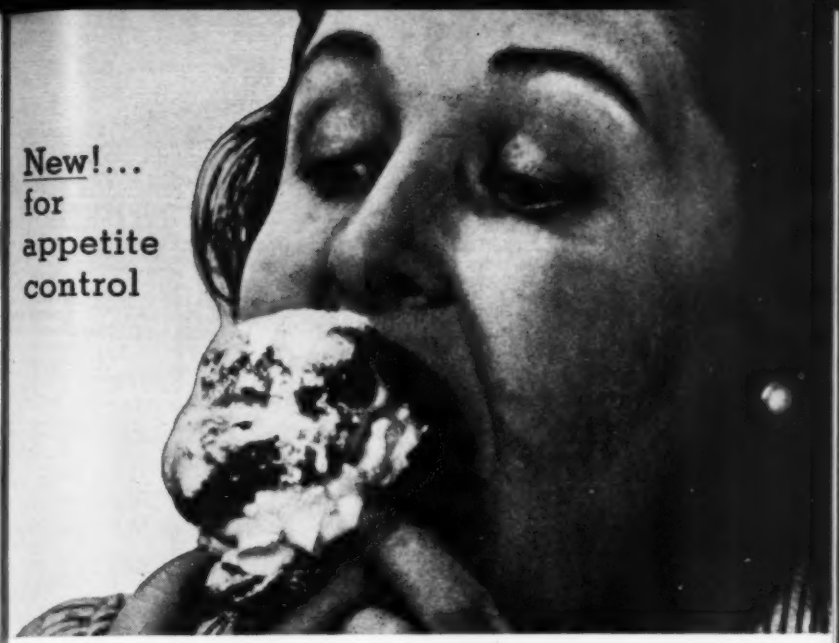
Both the service plan and the indemnity plan come in two strengths: high-option and low-option. First returns show that an overwhelming majority prefer the high-premium, high-benefit options. So let's skip any discussion of the low-option programs and take a quick look at the more popular, more comprehensive type of coverage:

It isn't cheap. For a family with children, the total monthly premium for the high-option service plan is $19.37. The Government pays $6.76 (regardless of which plan is chosen), leaving the worker with $12.61 to pay. On the indemnity plan, the employe pays $10.70 of the $17.46 monthly premium.

When the final tallies on enrollment are in, the medical profession will have a pretty good idea of how much value people put on first-dollar coverage under service plans, as opposed to higher total limits of coverage under indemnity plans. Then, too, the eventual report on the program's first-year experience should be of tremendous interest to the nation's doctors. It will provide a clear indication of whether the future of health insurance lies with fee-schedule plans, or with co-insurance and deductible plans that have no fee schedules, or even panel plans.

For More Information

On pages 118-119 and 122-123, you'll find an outline of the high-option benefits provided by both the service and indemnity programs. For further details (and there are plenty), write the Superintendent of Documents, Washington 25, D.C. Ask for two booklets coded BRI 41-24 and BRI 41-25. The cost will be 10 cents each. END



Controls compulsive overeating

CURBS APPETITE... RELIEVES TENSION HUNGER
TRANQUILIZES "DIET JITTERS"

Why do so many overweight patients so often break their diets?

The reason is usually tension. Now — Appetrol has been formulated to help you solve this problem.

Appetrol provides dextro-amphetamine to curb your patient's appetite. Even more important, it provides meprobamate to control compulsive overeating, to ease the frustration of the dietary regimen—and to minimize the jittery effects of amphetamine.

Thus, Appetrol does more than other anorectics which merely suppress appetite. Appetrol also tranquilizes tension hunger to give more complete control of compulsive overeating. Your patients find it easier to stay on their diets — even during prolonged periods.

Usual dosage: 1 or 2 tablets one-half to 1 hour before meals. Each tablet contains: 5 mg. dextro-amphetamine sulfate and 400 mg. meprobamate.

Available: Bottles of 50 pink, scored tablets.

Appetrol®
DEXTRO-AMPHETAMINE + MEPROBAMATE
for appetite control

WALLACE LABORATORIES/*New Brunswick, N. J.*

Cremomycin, provides rapid relief of virtually all diarrheas

NEOMYCIN — rapidly bactericidal against most intestinal pathogens, but relatively ineffective against certain diarrhea-causing organisms.

SULFASUXIDINE® (succinylsulfathiazole) — an ideal adjunct to neomycin because it is highly effective against Clostridia and certain other neomycin-resistant organisms.

KAOLIN AND PECTIN — coat and soothe the inflamed mucosa, adsorb toxins, help reduce intestinal hypermotility, help provide rapid symptomatic relief.

For additional information, write Professional Services, Merck Sharp & Dohme, West Point, Pa.

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CREMOMYCIN AND SULFASUXIDINE ARE TRADEMARKS OF MERCK & CO., INC.

What's Blurring Medicine's Image?

'Stand-pattism' is what the public sees when it looks at organized medicine. Yet the A.M.A. has shifted position on the greatest public issue facing it. Why doesn't medicine's image reflect this reality? Is overly cautious leadership to blame?

By John R. Lindsey

A.M.A. VOTES TO STAND PAT ON U.S. AID, said the page-one headline in the Miami Herald of June 16.

DOCTORS RAP U.S. CARE FOR INDIGENT, said the Miami News headline of the same date.

"Do those headlines tell the story of this A.M.A. meeting?" asked Dr. Joseph W. Crookshank, a G.P. from Lake Charles, La., as we turned down the spiral staircase that winds around the vine-covered volcano under glass in the half-Aztec splendor of the Americana Hotel lobby in Miami Beach. "I don't think so. But they show what sort of public image we're developing.

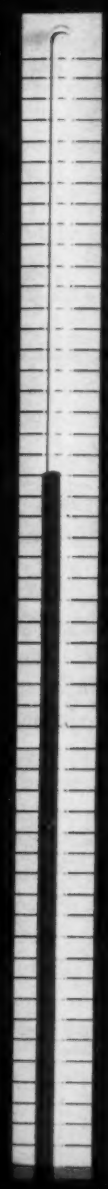
"On my way here just now, I was surprised to hear the limousine driver say, 'You know what these damn doctors did at this meeting? They came out against medical care for people over 65. They're against the old people!'

"Ridiculous? Of course. But

Continued on page 130

for a smooth downward curve

References: 1. Reports to the Squibb Institute, 1960. 2. David, N. A.; Porter, G. A., and Gray, R. H.: Monographs on Therapy 5:60 (Feb.) 1960. 3. Stenberg, E. S., Jr.; Benedetti, A., and Forsham, P. H.: Op. cit. 5:46 (Feb.) 1960. 4. Fuchs, M.; Moyer, J. H., and Newman, B. E.: Op. cit. 5:55 (Feb.) 1960. 5. Marriott, H. J. L., and Schamroth, L.: Op. cit. 5:14 (Feb.) 1960. 6. Ira, G. H., Jr.; Shaw, D. M., and Bogdonoff, M. D.: North Carolina M. J. 21:19 (Jan.) 1960. 7. Cohen, B. M.: M. Times, to be published. 8. Breneman, G. M. and Keyes, J. W.: Henry Ford Hosp. M. Bull. 7:281 (Dec.) 1959. 9. Forsham, P. H.: Squibb Clin. Res. Notes 2:5 (Dec.) 1959. 10. Larson, E.: Op. cit. 2:10 (Dec.) 1959. 11. Kirkendall, W. M.: Op. cit. 2:11 (Dec.) 1959. 12. Yu, P. N.: Op. cit. 2:12 (Dec.) 1959. 13. Weiss, S.; Weiss, J., and Weiss, B.: Op. cit. 2:13 (Dec.) 1959. 14. Moser, M.: Op. cit. 2:13 (Dec.) 1959. 15. Kahn, A., and Grenblatt, I. J.: Op. cit. 2:15 (Dec.) 1959. 16. Groliman, A.: Monographs on Therapy 5:1 (Feb.) 1960.



New Rautrax-N results in prompt lowering of blood pressure.[1] Rautrax-N, a new and carefully developed antihypertensive – diuretic preparation, provides improved therapeutic action[1] plus enhanced diuretic safety for all degrees of essential hypertension. A combination of Raudixin and Naturetin, Rautrax-N facilitates the management of hypertension when rauwolfia alone proves inadequate, or when prolonged treatment, with or without associated edema, is indicated.

Naturetin, the diuretic of choice, also possesses marked antihypertensive properties, thus complementing the known antihypertensive action of Raudixin. In this way a lower dose of each component controls hypertension effectively with few side effects and a greater margin of safety.[1-16]

Other advantages are a balanced electrolyte pattern[1-16] and the maintenance of a favorable urinary sodium-potassium excretion ratio.[2-16] Clinical studies[1-5] have shown that the diuretic component of Rautrax-N — Naturetin — has only a slight effect on serum potassium. The supplemental potassium chloride in Rautrax-N provides additional protection against potassium depletion which may occur during long term therapy.

Rautrax-N may be used alone or with other antihypertensive drugs, such as ganglionic blocking agents, veratrum or hydralazine, when such drugs are needed in occasionally difficult patients.

Supply: Rautrax-N—capsule-shaped tablets providing 50 mg. Raudixin (Squibb Rauwolfia Serpentina Whole Root) and 4 mg. Naturetin (Squibb Benzydroflumethiazide), with 400 mg. potassium chloride. Dosage: Initially — 1 to 4 tablets daily after meals. Maintenance — 1 or 2 tablets daily after meals; maintenance dosage may range from 1 to 4 tablets daily. For complete instructions & precautions see package insert. Literature available on request.

Squibb Quality — the Priceless Ingredient

SQUIBB

new

The proved, effective antihypertensive — now combined with a safer, better diuretic

RAUTRAX-N*

Squibb Standardized Whole Root Rauwolfia Serpentina (Raudixin) and Benzydroflumethiazide (*Naturetin) with Potassium Chloride

'RAUDIXIN'® 'RAUTRAX'® AND 'NATURETIN' ARE SQUIBB TRADEMARKS.

we're developing this image because we're not getting strong enough leadership. We're not moving forward overtly enough. The symptoms are in those headlines."

These same symptoms disturbed many other doctors at Miami Beach a month ago. They noted that the A.M.A. meeting was one of the quietest of all time—just when all hell seemed to be breaking loose on every other political and economic front. The A.M.A. turned thumbs down once again on Social Security for self-employed M.D.s. And on the most important public issue facing it, the A.M.A. moved reluctantly to support Federal aid to states and localities—but only as a last resort—to help pay medical care costs for the "medically indigent" over 65.

To be sure, this marked a shift of its position on Government help for old people's medical bills. Ever since the Forand bill was first introduced, the A.M.A. had said that voluntary insurance plans could take care of the need. Now the delegates appeared to be conceding that some form of Federal aid might be needed—especially in an election year.

But they crept into this new position with such caution that they received no public applause for adjusting to public opinion. As the local papers and the local limousine driver expressed it: The doctors don't want to help old folks!

How did medicine's policymakers manage to appear to be standing still, even while making an important move?

Careful Language

They took their cue from the A.M.A. Board of Trustees. The Board announced that it felt the A.M.A. "could support a public assistance program, including Federal funds," for medically indigent citizens over age 65. But this didn't mean it *did* support such a program, the Board cautioned. The key words in its statement were "*could* support," said Board Chairman Leonard W. Larson (who later was chosen president-elect of the A.M.A.). Added Dr. Larson: "There's no implication that we're support-

Continued on page 134

When there's a pram in her future,

She *knows*. And the moment is bright. Now... to preserve her serenity throughout the coming months. ■ One way is to make sure mother-to-be is getting the right kind of nutritional support—such as that provided by Pramilets. For Pramilets complement the sound dietary regimen you'll give your pregnant patient with: (1) phosphorus-free calcium; (2) well-tolerated iron, in the form of ferrous fumarate; and (3) the other essential vitamins and minerals. ■ Your patient will be grateful, too, for Pramilets' easy dosage schedule. In most cases, a Filmtab a day is all that's needed to carry her through term. ■ As for a reminder to take her daily supplement, the slim, graceful Table Bottle will take care of that.

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today.

ing the Mills bill—to provide Federal aid to the indigent and medically indigent over 65. There may be some small print in the bill we don't like. The Board has not endorsed this bill."

This equivocal statement confused some delegates and confounded others. "Is this leadership?" demanded Dr. Dwight H. Murray of Napa, Calif., a former A.M.A. president. "This sounds to me more like the girl who said 'Maybe.' The Mills bill could be the breakthrough to socialized medicine."

"The breakthrough came twenty years ago," responded another past president of the A.M.A., Dr. David B. Allman of Atlantic City, N. J. "We're not opposed to liberalized public assistance. This association regards it as a proper and reasonable Government activity."

Snapped back Ex-President Murray: "But there's no reason why this House of Delegates has to be bound by what previous Houses may have said. We could offer some new leadership now."

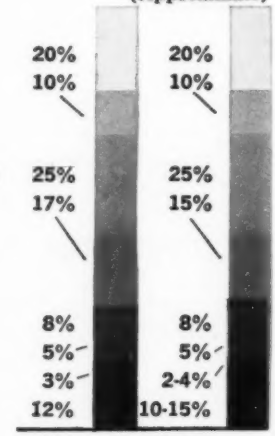
Without Conviction

In the end, the delegates did offer some leadership—though not the firm opposition to Federal aid that Dr. Murray had in mind. In fact, they came out in favor of Federal aid. But they did it with so little show of conviction that the public missed the point. Only as a last resort should Federal aid for the medically indigent over 65 be sanctioned, said the delegates in their final action. Financial aid for medical care should come first from the aging patient's family and then from his community, county, and state, in that order. "Only when these fail" should the Federal Government offer assistance—"and then

Continued on page 139

Veriderm, an original development from The Upjohn Research Laboratories, approximates qualitatively and quantitatively the oily constituents found in normal human skin.

CONSTITUENT	VERIDERM	HUMAN SKIN LIPIDS (Approximate)
I. Free Fatty Acids		
A. Unsaturated	20%	20%
B. Saturated	10%	10%
II. Saponifiable Material		
A. Triglyceryl esters of fatty acids	25%	25%
B. Other esters of fatty acids	17%	15%
III. Nonsaponifiable Material		
A. Hydrocarbons		
1. Saturated	8%	8%
2. Unsaturated	5%	5%
B. Free Cholesterol	3%	2-4%
C. Higher mol. wt. alcohols (liquid and solid)	12%	10-15%
	100%	100%



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- Corrects dry skin conditions associated with many dermatoses
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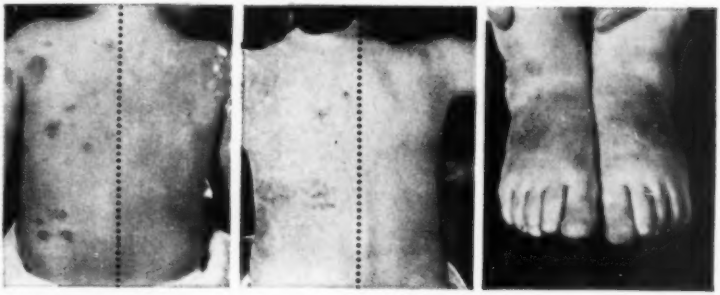
In Veriderm Medrol, the outstanding anti-inflammatory agent Medrol (methylprednisolone acetate) is available for the first time for topical corticotherapy. The great potency of Medrol (5 times that of hydrocortisone) and speed of action make it ideally suited for dermatological use.

Infantile eczema (3 months duration) after 9 days on Veriderm Medrol 1% b.i.d. on right side of body. Itching controlled in 1 day.

Infantile eczema (6 months duration; unresponsive to previous medication, both topical and systemic) shown after 6 days on Veriderm Medrol 1%, once a day on right side of body. Itching controlled in 2 days.



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Available as:
Veriderm Medrol Acetate 0.25% and 1.0%, in 5 Gm. tubes containing 0.25% and 1.0% Medrol acetate in skin lipid base.

Veriderm Neo-Medrol Acetate 0.25% and 1.0% — for infected dermatoses — in 5 Gm. tubes containing 0.25% and 1.0% Medrol acetate plus 0.5% Neomycin sulfate in skin lipid base.

- Dramatic results in a minimum of time in allergic dermatoses
  - neurodermatitis
  - contact dermatitis
  - anogenital pruritus
  - atopic dermatitis
  - seborrheic dermatitis

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only in conjunction with the other levels of government, in the above order."

The final action seemed to epitomize what one delegate had said earlier about giving ground. Dr. C. Byron Blaisdell of Asbury Park, N.J., had been speaking satirically of leadership-in-reverse: "Don't give ground unless you have to. But if you have to give ground, give ground grudgingly."

A state medical society trustee, Dr. Harmon L. Monroe of Erwin, Tenn., said afterward: "I'm sorry we didn't take a stronger position that would give medicine a voice in something that is surely coming. We in Tennessee wanted to make sure that aid to the aged would be under the control of medicine. Obviously, we can't turn off the spigots of Fed-

Can You Name These Doctors?

(Answers to the quiz on page 102)

1. Dr. Bobby Brown.
2. Dr. Juscelino Kubitschek, President of Brazil.
3. Dr. Keiko Kawakami.

eral aid to the states. Since we can't, I'd like to see medicine take charge. I'm not in favor of waiting until we're swamped so we can't move."

Two weeks after the meeting had ended, A.M.A. leaders did take a less confusing stand. They testified before the Senate Finance Committee in support of the Mills bill—the same bill they'd declined to support at Miami Beach. It provides the aged who're medically indigent with Federal help for their medical bills, but as a new kind of Federal public assistance. Unlike Forand-type proposals, it does not cover all retired persons on Social Security. Some observers still suspect, however, that this show of leadership came too late to correct the public's impression of A.M.A. stand-pattism in the matter of aid to the aged.

Blurring medicine's image still further is some genuine A.M.A. stand-pattism on the issue of Social Security. This, too, troubled many doctors at Miami Beach. As Dr. Roscius C. Doan of Mi-

Continued on page 144

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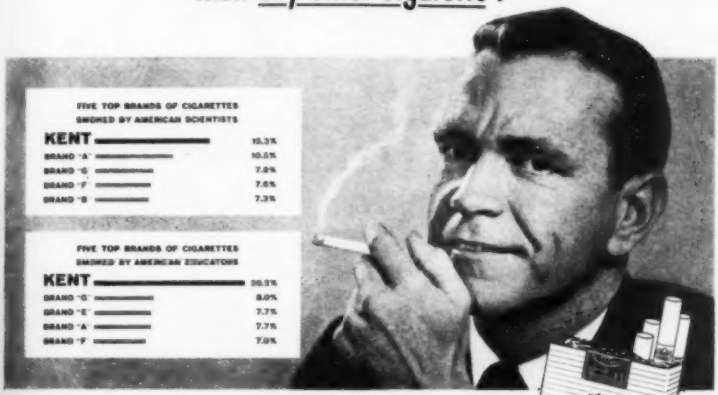
KENT with the MICRONITE FILTER IS SMOKED BY MORE SCIENTISTS and EDUCATORS

than any other cigarette !*



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MER/29[1-41] is not a cholesterol-lowering agent by the usual definition. Usual measures for lowering cholesterol only modify its intake or accelerate its metabolism. Since dietary cholesterol is the minor source of total body cholesterol, results with previous agents have been limited.

MER/29, however, *inhibits* cholesterol *biosynthesis* in the liver and other tissues.[1-4] This activity is partial and takes place at a late stage in the synthesis cycle. Sufficient cholesterol remains to fulfill its role as precursor of other necessary biosynthesized substances.

Thus MER/29 is an inhibitor of *excess* cholesterol *production;* and reduced cholesterol levels in both serum[3-6] and tissues[2,4,7] is the net result of this activity. Studies of Hollander and Chobanian,[3] and those of Oaks *et al.*,[6] found cholesterol levels were lowered irrespective of diet.

In clinical studies[3-6] MER/29 reduced cholesterol, on the average, 48 mg.%, and reduction ranged from 20 to 110 mg.%. Maximum reduction was reached in 5 to 8 weeks.

A report on MER/29 therapy for patients with hypercholesterolemia and its probable associated conditions:

- coronary artery disease (angina pectoris, postmyocardial infarction)
- generalized atherosclerosis

In some instances,[3-6] MER/29 increased exercise tolerance in patients with angina pectoris. Frequency and severity of anginal attacks were reduced, as was nitroglycerine dependence. Abnormal ECG's did not occur in these patients at the previous levels of exercise. Many of them reported improved sense of good health and well-being. Explanation of these clinical benefits is not yet known. Nevertheless, they prompt mounting interest in MER/29 as an important new agent.

It is equally important that MER/29 has been well tolerated and relatively free of toxic effects. Clinical liver damage has not been encountered; however, since the principal site of action of MER/29 is in the liver, periodic hepatic function tests may be desirable until more long-term safety data are available.

Available: Bottles of 30 pearl gray capsules.

MER/29

1. MacKenzie, R. D., and Blohm, T. R.: Fed. Proc. *18*:417, 1959. 2. Blohm, T. R.; Kariya, T., and Laughlin, M. W.: Arch. Biochem. *85*:245, 1959. 3. Hollander, W., and Chobanian, A. V.: Boston M. Quart. *10*:37, 1959. 4. Kountz, W. B.: Proceedings, Conference on MER/29, Progr. Cardiovasc. Dis. *2*: (Suppl.), 541 (May) 1960. 5. Oaks, W., and Lisan, P.: Fed. Proc. *18*:428, 1959. 6. Oaks, W.; Lisan, P., and Moyer, J. H.: Arch. Int. Med. *104*:527, 1959. 7. Blohm, T. R.; Kariya, T.; Laughlin, M. W., and Palopoli, F. P.: Fed. Proc. *18*:369, 1959. 8-41. Additional references available on request.

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amisburg, Ohio, told me: "I think a good many doctors are disturbed about the A.M.A.'s opposition to Social Security coverage for M.D.s. I myself can't help wondering if our leaders are worrying enough about the rights of the rank-and-file doctor."

What struck Dr. Doan was that the A.M.A. House of Delegates voted *unanimously* against inclusion of all physicians under Social Security. Reference committee hearings had made it clear that doctors throughout the country are anything but unanimous on the subject. Said Dr. Alvia G. Young of Wenatchee, Wash.: "In the State of Washington, our official faces are pretty red. Last September, our state society's House of Delegates opposed inclusion of doctors under Social Security. Just last month, a poll of our members brought an 80 per cent response. And 60 per cent of those voting came out for Social Security."

Asked a Connecticut delegate: "Is this House of Delegates really knowledgeable about how

Continued on page 148


Deltoid bursitis
Analgesics alone merely mask pain. New Medaprin adds Medrol* to suppress the inflammation that *causes* the pain and stiffness. Thus, to the direct relief of musculoskeletal pain,
Medaprin†
adds restoration of function.
Medaprin is supplied in bottles of 100 and 500 tablets, each containing: 300 mg. acetylsalicylic acid for prompt relief of pain; 1 mg. Medrol to suppress the causative inflammation; 200 mg. calcium carbonate as buffer.
*Trademark, Reg. U.S. Pat. Off.— methylprednisolone, Upjohn
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NOW in contact dermatitis
for fast relief...press and release

- prompt relief of burning and itching
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DEXAMETHASONE–NEOMYCIN SULFATE

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Dosage: Apply to the affected area 2 or 3 times a day. Dosage may be adjusted up or down depending upon severity of the disorder. Hold aerosol container approximately 6 inches from the affected area and allow a one- or two-second spray for each 4-inch-square area to be treated (i.e., one second for an area the size of the back of the hand). Each second of spray dispenses approximately 0.075 mg. of dexamethasone and 0.375 mg. of neomycin sulfate.

Supplied: In 90-Gm. seamless, pressurized cans, containing 10 mg. dexamethasone and 50 mg. of neomycin sulfate (equivalent to 35 mg. neomycin base).

Additional information on DECASPRAY is available to physicians on request.

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MSD

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A.M.A. members stand? Our state polls indicate that a majority of physicians want to be included in Social Security. Yet the Connecticut delegation to this meeting is opposed to such inclusion . . . even though a majority of the state society's members may be in favor."

Stand-pattism—whether real or only apparent—is clearly costing the A.M.A. some professional support as well as some public support. That's why this blurred image was much talked about at Miami Beach.

Even the newly installed A.M.A. president, Dr. E. Vincent Askey of Los Angeles, joined in.

"If it's necessary to establish a favorable image of the A.M.A. in the minds of the general public," he said, "it's equally important to establish an even stronger image in the minds of our own members. We should direct closer attention to the thousands of physicians who are not now members of the association. In some states, the numbers of such physicians seem to be disproportionate."

Continued on page 153

NEW

INSTANT MIX

just pour powder from one packet

• each packet is equivalent to one rounded teaspoonful of Metamucil powder.

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add cool water slowly ...it's instantly mixed

• all the advantages of smoothage therapy in the relief and correction of constipation

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XUM

High in flavor but low in fat: kabobs, salad with cottage cheese dressing, angel cake with whipped skim milk topping

The secret of a successful low-fat low-cholesterol diet is acceptance

Palatability is the key to this special diet. And these dishes have real appetite appeal.

Lamb kabobs are low in fat; so are "surprise" hamburgers with a slice of pickle or onion sandwiched between two thin patties. Cranberry and tomato sauce pinch-hit for gravy and are marvelous with meat loaf. Chicken may be basted with lemon and herbs or a dash of orange juice.

On green salads, cottage cheese thinned with lemon juice makes the dressing. For a delicious diet dessert, angel cake goes nicely under fruits—skim milk powder makes the "whipped cream."

And with your approval, a glass of beer can add zest to your patient's diet.

Fat 0; calories 104/8 oz. glass (Average of American Beers)

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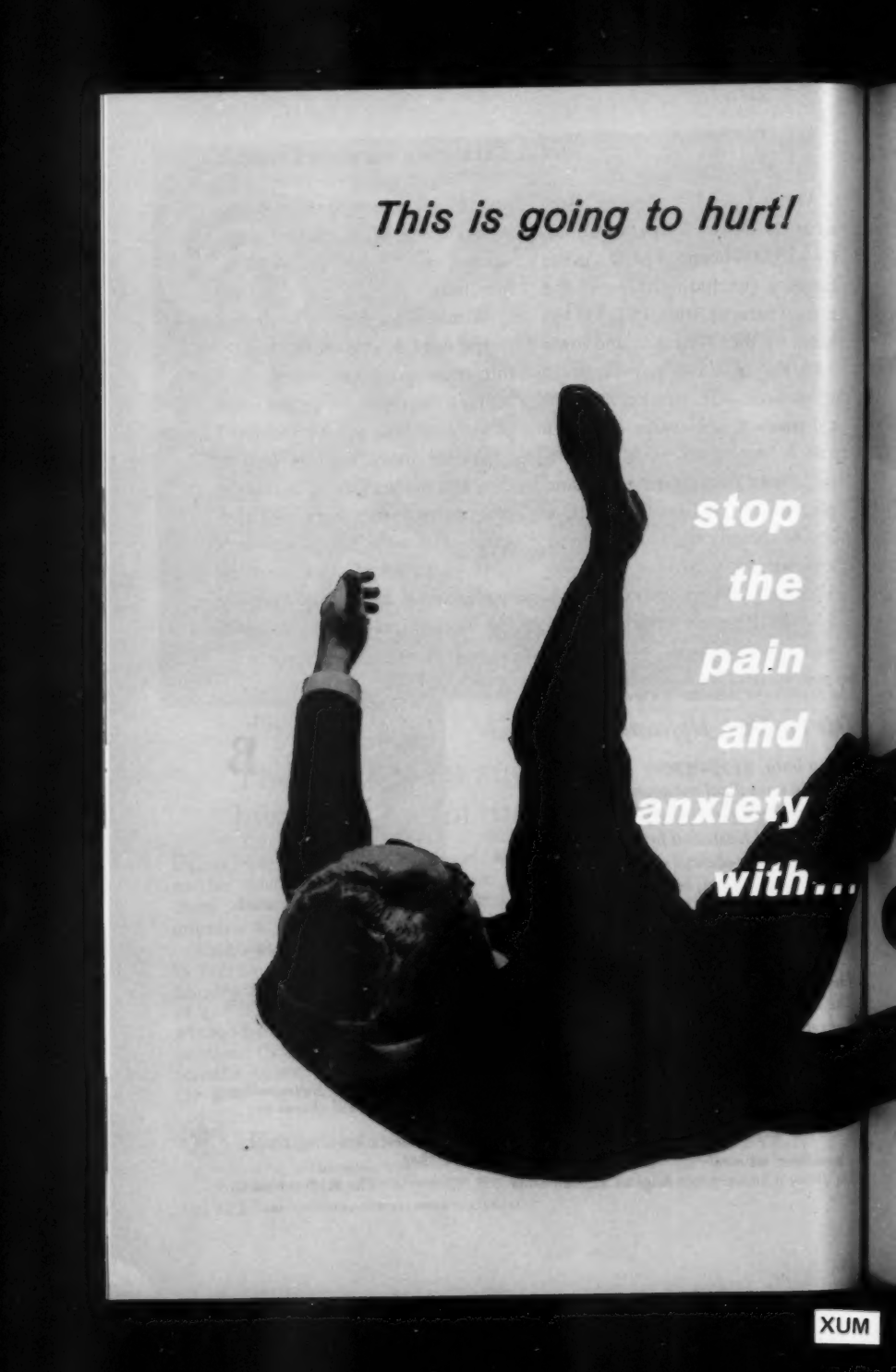
If you'd like reprints of this and 11 other different diet menus for your patients, write United States Brewers Foundation, 535 Fifth Avenue, N. Y. 17, N. Y.

Official A.M.A. figures show what Dr. Askey is worried about. Of 220,000 licensed M.D.s in the country (excluding those in the armed forces), only 157,000 belong to the A.M.A., and only 140,000 of these pay dues. In some areas, the gap between local medical society membership and A.M.A. membership is glaring. New York State, for example, has 31,000 licensed M.D.s, 25,000 county and/or state medical society members, but only 17,000 A.M.A. members. Of 11,000 licensed Ohio doctors, only 8,800 belong to the A.M.A. And of 8,900 Massachusetts physicians, only 5,200 are A.M.A. members.

Would more doctors be drawn to the A.M.A. if it moved boldly into new positions when they seemed justified—as on the issue of Government aid for oldsters?

Would more doctors join if they felt the leadership would be responsive to members' wishes—as on the issue of Social Security?

If they would, less cautious leadership is clearly the cure for the blurred image. END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stop
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for moderate
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fulfills all the
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provides analgesia equivalent to that of codeine, but without many of its liabilities

relieves anxiety
relieves the anxiety that magnifies pain and contributes to tension

relieves muscle spasm and tension
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EQUAGESIC is highly effective in pain involving bones and skeletal muscles, particularly traumatic and arthritic disorders; headache, dysmenorrhea, neuritis, and neuralgia.

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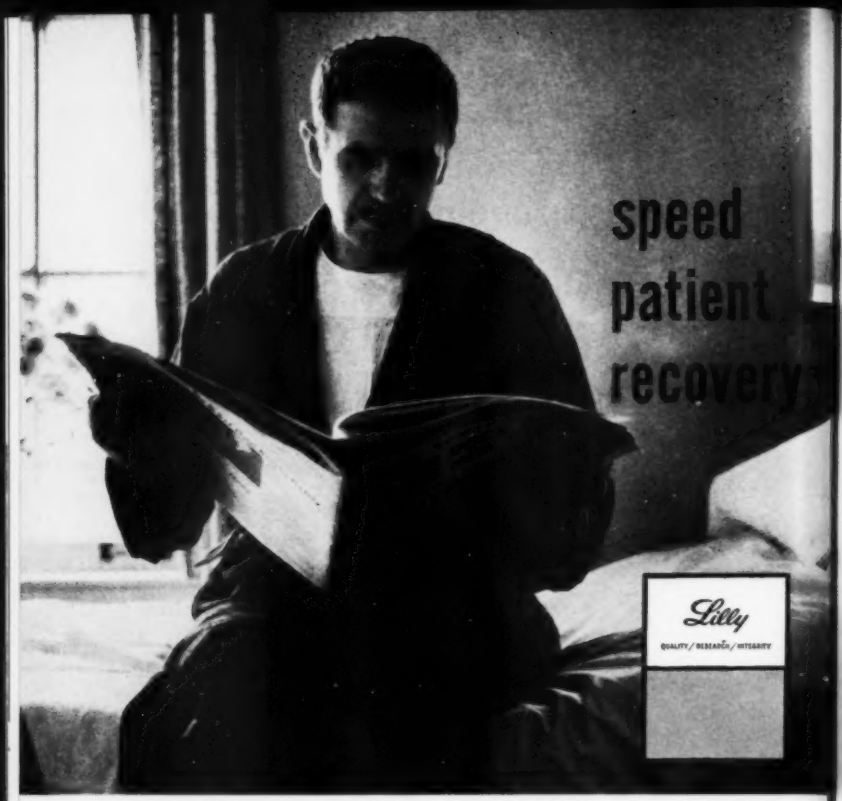

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1. Spies, T. D.: Some Recent Advances in Nutrition, J.A.M.A., *167*:675, 1958.

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Alert Yourself to Drug-Allergic Patients

BY MATTHEW A. STROUP JR., M.D.

Two of my patients had severe penicillin reactions last year. This set me to wondering about the best way to record such important information in my office records. I'd been using regular tan-colored folders for all of my patients' charts. Each time I discovered a patient had an allergy to a certain drug, such as penicillin, I'd write that fact on the outside of the folder.

But I found that my system wasn't sure-fire. Sometimes, when I was rushed, I'd overlook the note on the folder. So I tried to figure out a better system, but with little success for a while.

Then one day in a stationery store, I noticed a pile of colored folders, similar in size and shape to the ones I'd been using in my office. The colored folders looked to be exactly what I needed to distinguish the various allergies of my patients.

Now I assign a colored folder to each patient with an allergy to a particular drug. For instance, records of all patients with an allergy to penicillin are placed in blue folders. Other colors are assigned for other types of allergies. So when I come across a colored folder, it instantly alerts me to the patient's allergy, and I don't have to worry about overlooking it—even when I'm in a hurry.

If all doctors used this simple precaution, I feel that many lives could be saved. END

Lifts depression...

You see an improvement within a few days
Thanks to your prompt treatment and the smooth action of Deprol, her depression is relieved and her anxiety and tension calmed – *often in a few days.* She eats well, sleeps well and soon returns to her normal activities.

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as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

Balances the mood – no "seesaw" effect of amphetamine-barbiturates and energizers.

While amphetamines and energizers may stimulate the patient – *they often aggravate anxiety and tension.*

And although amphetamine-barbiturate combinations may counteract excessive stimulation – *they often deepen depression.*

In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety – both at the same time.

Acts swiftly – the patient often feels better, sleeps better, within a few days.

Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly – often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely – no danger of liver damage.

Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function – frequently reported with other antidepressant drugs.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

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Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate. **Supplied:** Bottles of 50 light-pink, scored tablets. Write for literature and samples.

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Cynal provides not only generous amounts of B_{12} but also B_1 and B_6 as valuable adjuncts to absorption.[2]

EACH "CHERRO-CHEW" TABLET CONTAINS:

Thiamine mononitrate (vitamin B_1)	10 mg.
Vitamin B_{12} (as L. B.®12*)	25 mcg.
Pyridoxine hydrochloride (vitamin B_6)	5 mg.

*Lloyd's absorption-enhancing complex of vitamin B_{12} (B_{12} from Cobalamin Concentrate).

DOSE: One tablet per day.

SUPPLIED: Bottles of 50 tasty "Cherro-Chew" tablets.

REFERENCES: 1. Chow, B. F.: Gerontologie 2:213-221, 1958. 2. Chow, B. F., et al.: Am. J. Clin. Nutrition 6:386, 1958.

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CINCINNATI 3, OHIO

Doctors and attorneys frequently misunderstand each other's problems, declares this medicolegal expert. Both would benefit, he suggests, if more doctors learned

How to Get Along With the Lawyer In an Accident Case

By Stanley Tessel, LL.B.

How little most lawyers and physicians know about each other! I'm often struck by this fact when I handle accident cases. Many doctors seem to resent the trouble I cause them. They seem to feel that I make unnecessary demands on their time. At least to some extent, I understand and sympathize with this point of view.

But with due deference to the medical profession, may I make a deposition on the side of the bar? I feel strongly that physicians who expect to benefit from accident cases don't always live up to their obligations, either to the patients or the attorneys concerned. What are a doctor's obligations? I think they're these:

1. To give the patient's attorney a prompt, full, and detailed report of his findings. This should include a description of the patient's condition and how it was treated, the doctor's opinion on the connection between the accident and the condition treated, and his prognosis. Personally, I believe the attorney should pay a fee for such a report, and I always do. Yet all too often I've received reports that were either so

long delayed or so cryptic that they were of little value in the patient's case.

2. To permit the patient's attorney to borrow X-rays of the patient. They're often needed for demonstration to the insurance carrier's physician. Or the patient may want to get another opinion on them.

3. To furnish on request a detailed, itemized bill for medical services rendered. In cases of protracted treatment, a reasonable number of interim bills ought to be prepared. These need not be a "bargain" or a "sacrifice" by the physician; they should be fair and reasonable. Incidentally, it's the extent of the patient's injuries rather than the size of his bill that determines the value of his case.

4. Most important of all, to come to court on reasonable notice and for a fair fee. I believe this is the greatest duty the physician owes. Of course, it's an accident-witness' duty to tell in court what he has seen. But such a witness can testify about just one part of a two-part case: the question of responsibility for the accident. Only the medical witness can supply the second element of proof: the extent of the damage done. Both are parts of the whole. Justice cannot be done without them.

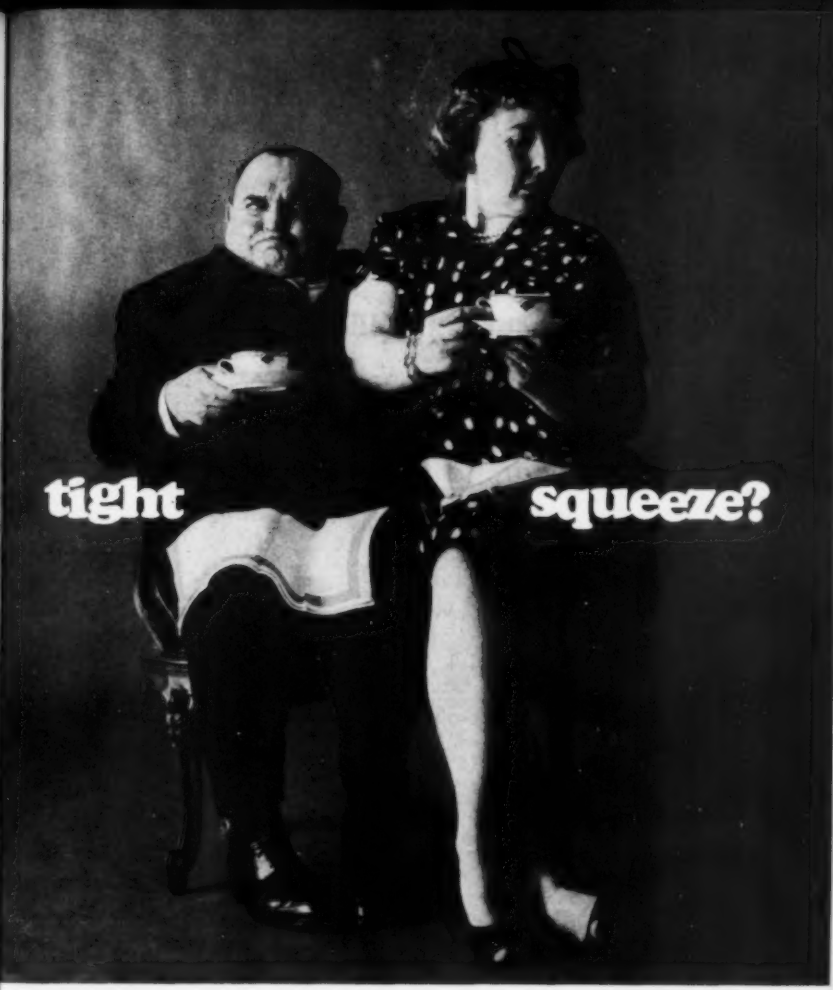
No patient can be compensated, no matter how serious his injury, without the testimony of a doctor. And usually that doctor has to be the treating physician. His presence in court is practically indispensable. If he's absent, the judge may instruct the jury to infer that he stayed away because his remarks would not have helped his patient.

What's Reasonable Notice?

Few physicians recognize this interpretation of their presence in the courtroom. Even fewer recognize the meaning of "reasonable notice" from the lawyer. Strange as it may seem, the attorney never knows until the morning of actual trial that he'll be ordered to proceed. So there's no way he can give earlier notice. I don't blame physicians for be-

Continued on page 166

THE AUTHOR *is a partner in the New York law firm of Turkewitz and Tessel. He specializes in accident and related cases.*



NEEDED: THE APPETITE SUPPRESSANT STRONG ENOUGH AND SAFE ENOUGH TO DO THE JOB

Ambar controls many cases of overeating/obesity refractory to usual therapy. To strengthen the will for successful dieting, the methamphetamine-phenobarbital in Ambar is designed to improve mood without harmful CNS overstimulation. Available in different forms to enable individualization of dosage: **AMBAR #1 EXTENTABS,** 10-12 hour extended action tablets, methamphetamine HCl 10.0 mg., phenobarbital 64.8 mg. **AMBAR #2 EXTENTABS,** methamphetamine HCl 15.0 mg., phenobarbital 64.8 mg. Also conventional **AMBAR TABLETS,** methamphetamine 3.33 mg., phenobarbital 21.6 mg.

Robins

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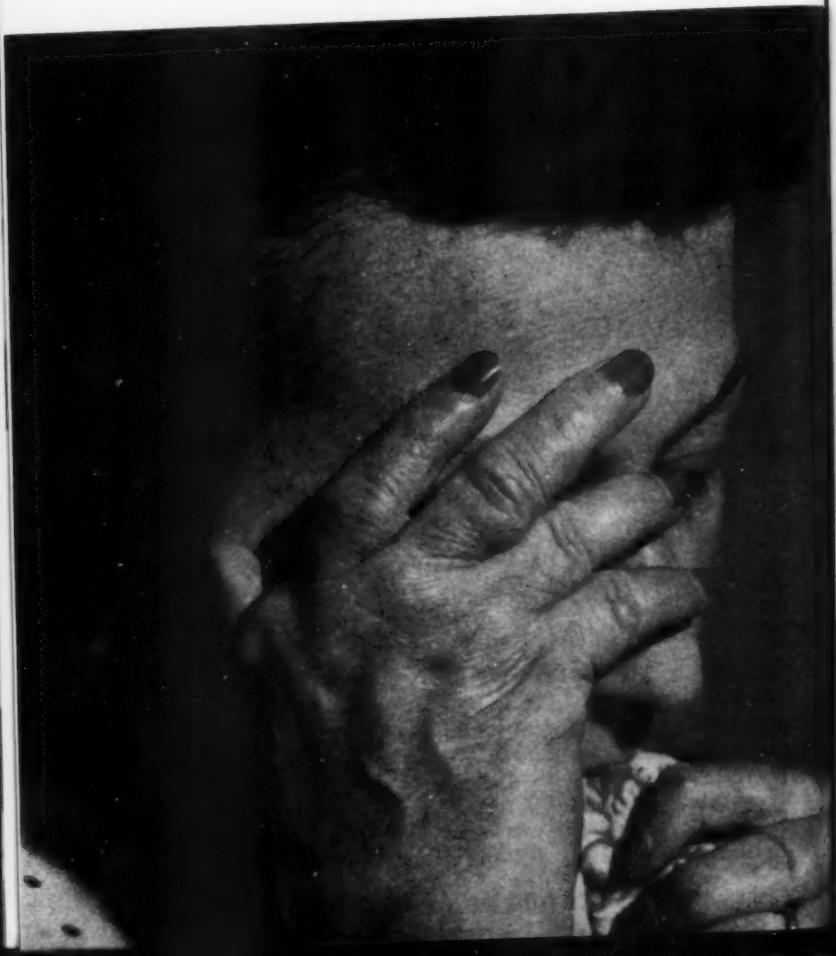
Ambar™ #1 Extentabs® / Ambar™ #2 Extentabs®

NEW for arthritic

SOMAcor

eases pain • reduces inflammation • relaxes muscl



More complete freedom from pain with reduced steroid dosage

New therapy for acute and chronic arthritics, offering:

Effective analgesic / muscle relaxant action with Soma®

eases pain rapid analgesic action provides long-lasting pain relief.

relaxes muscles prompt muscle relaxant action relieves muscle spasm and protects against spasm-induced disabilities.

when painful muscles relax
inflamed joints need less steroid.

Potent anti-inflammatory action with prednisolone

reduces inflammation reliable anti-inflammatory action reduces swelling, tenderness, stiffness and pain, with reduced steroid dosage for well-tolerated long-term use.

continuous anti-inflammatory action halts inflammation-induced joint damage.

SOMAcort

(carisoprodol, Wallace, with prednisolone)

USUAL DOSAGE: One or two SOMACORT Tablets four times daily.

SUPPLIED: As white, scored tablets, each containing 350 mg. of SOMA (carisoprodol Wallace) and 2 mg. prednisolone. Bottles of 50.

Free literature and samples on request.

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ing disturbed by this deplorable situation. Lawyers are, too. But the inconvenience to the physician (and I don't make light of it) doesn't justify his depriving the injured patient of his right to a fair trial.

So much for the obligations a doctor owes. In view of these obligations, what should he charge for his cooperation?

My answers will be clearer if I first explain something about the attorney's place in the picture. While a doctor is comparatively sure of his fee in an accident case, the attorney isn't. He often gets it on a contingent basis: that is, if his suit is successful. Historically, this arrangement grew up so that people wouldn't be denied their day in court simply because they could not pay for it. More often than most doctors seem to realize, lawyers lose hundreds and even

"There are times when I feel like chucking it all and going off to sell blood pressures on the boardwalk at Atlantic City."

thousands of dollars in the time and money they spend on an accident case. Even when they are compensated, they sometimes have to wait five years and longer to be paid.

Because of these special circumstances, I feel that what the lawyer receives should in no way influence the physician in either fixing or collecting his own well-deserved fee. Here's a second reason I feel this way:

An attorney isn't permitted to pay the expenses of a lawsuit out of his own pocket. He may *advance* those expenses—but only with the understanding that the client will reimburse him. Thus, it's the patient who ultimately pays the doctor's fee, even if the case is lost.

So I respectfully suggest that physicians set a charge for a courtroom appearance that's related not only to the time and trouble it involves, but to the nature of the injury and the *patient's* (not the attorney's) ability to pay. For what it's worth, here's a list of the fees I feel a physician might fairly charge for

an appearance at various kinds of accident trial:

▶ In cases of minor injuries:

FAMILY PHYSICIAN with no office hours at time of testimony ..... $ 50
During office hours ... 100

▶ In cases of serious injuries:

FAMILY PHYSICIAN with no office hours at time of testimony ..... $ 75
During office hours ... 125
ORTHOPEDIC SURGEON, no surgery performed 150
No surgery, treatment varied and protracted ... 175
Surgery, no permanent disability 200
Surgery performed, permanent disability 250
RADIOLOGIST, condition clear, not contradicted.. 100
Findings disputed 150
OTHER SPECIALISTS, no question of causal relationship between condition and accident 150
Question disputed 250

▶ In medical malpractice cases $500

How does the widely discussed legal assignment form fit into this scheme? I'm whole-heartedly in favor of doctors' using such forms to authorize direct payment to them out of the proceeds of the case. Without this authorization, it's none of the lawyer's business whether or not his client pays the bill that's owed the doctor. The attorney is actually prohibited by law from paying his client's medical bills out of his own pocket.

There's one type of special situation where the doctor may do well to reduce his charges to the accident patient. The situation I'm talking about is the sort where there are extensive medical and hospital bills, all wrapped up in a lawsuit of an almost hopeless nature. In such a case, the plaintiff often owes a large sum to a hospital as well as to his physician. Under normal circumstances, none of these bills would be paid.

Let's say that a diligent and resourceful attorney tackles the case. He works hard and long on it. As a result, a settlement is sug-

Continued on page 174

In over five years

...for the tense and nervous patien

Despite the introduction in recent years of "new and differen
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gain in acceptance. Meprobamate (Miltown) is prescribed b
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The reasons are not hard to find. Miltown is a ***known*** dru
Its few side effects have been fully reported. ***There are n***
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Proven
in more than 750 published clinical studies

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Outstandingly Safe

1. simple dosage schedule produces rapid, reliable tranquilization without unpredictable excitation
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5. does not impair mental efficiency or normal behavior

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meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; or as MEPROTABS® — 400 mg. *unmarked*, coated tablets. ®TRADE-MARK

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CM-2539

gested. This offer is probably small by comparison with the extent of the injuries and the bills. Just the same, the sensible attorney recommends that his client accept the offer. And the client often replies, "No. Go to trial. I'll take my chances."

The client is right. Because of his extensive medical bills, a settlement would leave him little or nothing. So the case goes to court. The client loses. So do the doctor and the hospital.

In cases like this, a motive for settlement must exist. And it's to the doctor's advantage to make it possible by cutting his fee.

The same sort of problem is presented in cases of clear liability where there's a limited amount of liability-insurance coverage. Here, too, the doctor may do well to reduce his fee. In this type of case, the attorney usually reduces his fee, too. Reason: The settlement is obtained because of the inherent value of the case rather than through the lawyer's efforts. END

Low octane

One of the Medical Arts Building doctors was boasting at lunch about his new European car. "I get terrific gas mileage," he said.

"How much is 'terrific'?" asked a colleague.

"Well," the proud owner replied, "I can't say *exactly* till I have to fill her up again. No gas gauge, you know."

His companions had a little meeting after lunch. During the next few weeks, one of them would casually ask him every few days about the gas mileage.

"It's phenomenal!" he'd say. "I haven't had to buy a drop of gas, and she's still going strong."

Then one day he left his office early on an emergency call. There in the parking lot, he caught his colleagues redhanded. They were pouring into his gas tank their agreed-on daily gallon of gas. —BETTY JOHN

specify Bufferin® and avoid salicylate intolerance

Gastric distress due to aspirin used alone is being reported with increasing frequency.[1-7]

BUFFERIN is superior to plain aspirin in that it avoids gastric intolerance; it is ". . . the drug of choice where prolonged, high salicylate levels are indicated."[8]

". . . is 4 to 5 times better tolerated than ordinary aspirin."[8]

Swift-acting BUFFERIN is detectable in the plasma 60 seconds after oral ingestion,[9] its absorption being expedited by the presence of antacid.[10]

1. Muir, A., and Cossar, I.A.: Brit. M.J. *2*:7-12 (July 2) 1955. 2. Waterson, A. P.: Brit. M. J. *2*:1531 (Dec. 24) 1955. 3. Brown, R. K., and Mitchell, N.: Gastroenterology *31*:198-203 (August) 1956. 4. Kelly, J. J., Jr.: Am. J. Med. Sci. *232*:119-128 (August) 1956. 5. Brick, I. B.: J. Am. Med. Assn. *163*:1217-1219 (April 6) 1957. 6. Trimble, G. X.: Correspondence, J. Am. Med. Assn. *164*:323-324 (May 18) 1957. 7. Lange, H. F.: Gastroenterology *33*:770-777 and 778-788 (Nov.) 1957. 8. Tebrock, H. E.: Ind. Med. & Surg. *20*:480-482, 1951. 9. Harrisson, J. W. E.; Packman, E. W., and Abbott, D. D.: J. Am. Pharm. Assn. (Scient. Ed.) *48*:50-56 (Jan.) 1959. 10. Paul, W. D.; Dryer, R. L., and Routh, J. L.: J. Am. Pharm. Assn. (Scient. Ed.) *39*:21 (Jan.) 1950.

FOR A COMPLIMENTARY SUPPLY OF BUFFERIN WRITE:
BRISTOL-MYERS COMPANY, DEPT. BU-13, 630 FIFTH AVENUE, NEW YORK 20, NEW YORK

It Pays to Split Your Billing File

BY RICHARD V. BIBBERO

Medical insurance plans are turning the monthly billing chore into an increasingly complex operation in many physicians' offices. So much so that my firm is advising clients to break with traditional filing.

Instead of the single, inclusive file of active ledger cards, I now recommend a three-way breakdown. Grouping of the cards is determined by the question: Who's going to pay the bill? My system can save you needless headaches and confusion. Here's the breakdown:

SECTION 1. This file houses the cards of patients who are *personally responsible* for all or part of their bills. It includes not only your uninsured patients but also those who, though covered, chip in the difference between your fee and the carrier's liability.

SECTION 2. This contains the cards of all patients whose bills are due to be *paid in full by a third party*. (The payment may not be enough, but it's all you're going to get.) These are the "service plan" cases, persons on Workmens' Compensation, the welfare patients. Here also will go the card of any patient involved in a personal-injury suit

Continued on page 180

THE AUTHOR *is president of Medical Management Control, Inc., San Francisco.*

Permitil approaches the ideal in anti-anxiety therapy

■ A significantly wider range of anxiety symptoms amenable to therapy

PERMITIL "mitigates apathy, indifference, inertia and anxiety-induced fatigue."[1]

■ A higher percentage of favorable results

Significant improvement in over 90% of patients treated.[2,3]

■ A lower incidence of side effects

At recommended dosage levels, virtual freedom from autonomic, endocrine or neuromuscular (extrapyramidal) side effects.

■ A greater specificity of action

Patients become calm without drowsiness, mental acuity is sharpened and normal drive is restored.

And now ■ The simplest dosage schedule of all

In the large majority of adults, only one PERMITIL CHRONOTAB, taken upon arising, controls anxiety and anxiety-induced symptoms *all day long*.

Sig: One Permitil Chronotab (1mg.) in the morning

Side effects from PERMITIL, at the recommended dosage, have been observed infrequently or not at all. PERMITIL, as with other phenothiazines, is contraindicated in severely depressed states. *Complete information concerning the use of this drug is available on request.*

PERMITIL CHRONOTABS, 1 mg., bottles of 30. Also available PERMITIL TABLETS, 0.25 mg., bottles of 90.

CHRONOTAB is White's sustained-action tablet.

REFERENCES: 1. Ayd, F. J., Jr.: Current Therap. Res. 1:41, 1959. 2. Recent compilation of case reports received by the Medical Department, White Laboratories, Inc. 3. Ernst, E. M.: Clin. Med. (In press). Additional bibliography: Bedi, T., et al.: Clin. Res. 8:72, 1960. Dunlop, E.: Personal communication. Grimaldi, R.: Presented at Annual Congress of Pan-American Medical Association, May 6, 1960, Mexico City. Glass, J., and Cawley, S. H.: Personal communication.

WHITE LABORATORIES, INC., KENILWORTH, NEW JERSEY

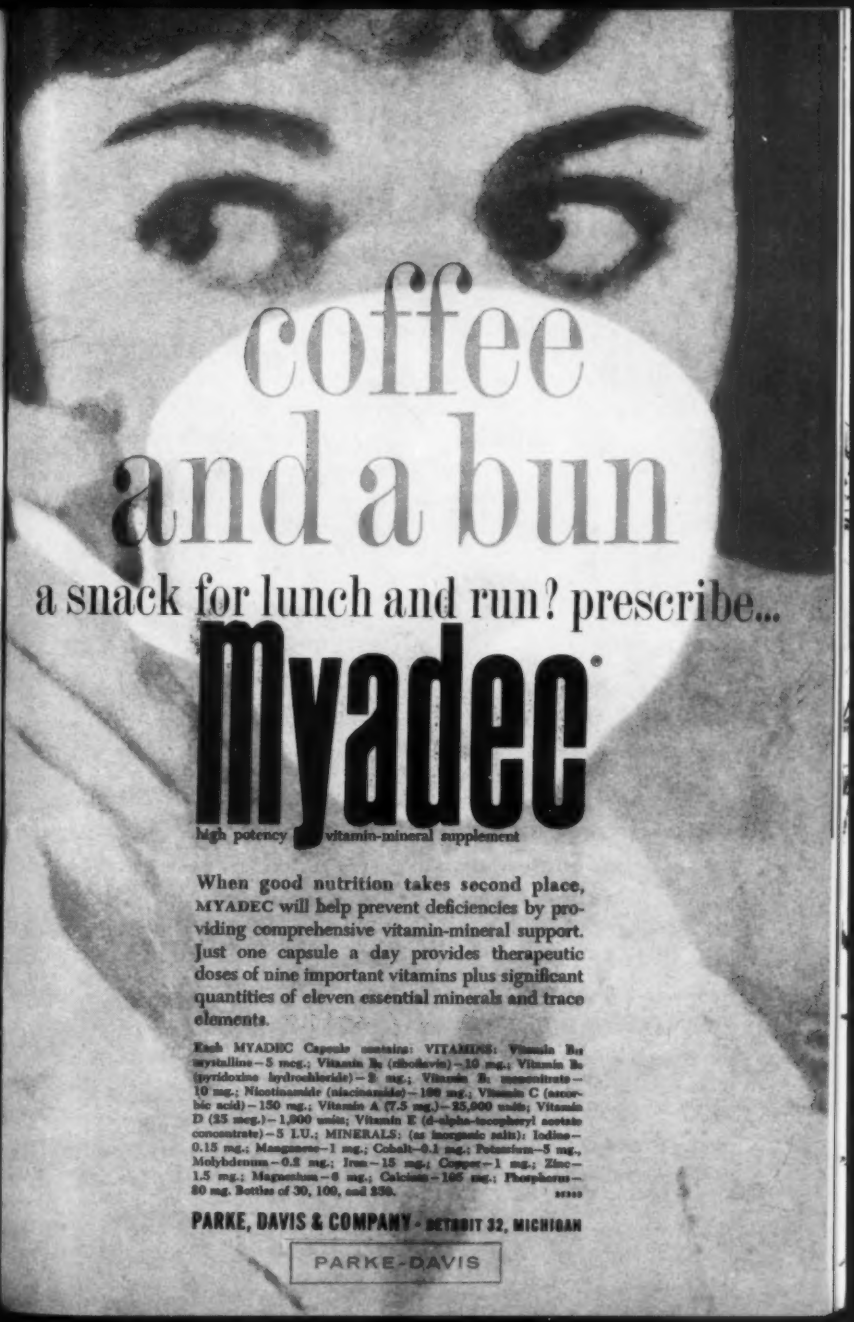
in which the defendant may be found liable for your entire bill.

SECTION 3. Here are grouped the cases in which payment is to be *shared* by the patient and a third party. Mostly, they'll be patients whose insurance has a "deductible" feature. This type of policy requires the patient to pay, say, the first $100 of your bill, with the insurance company accepting responsibility for the rest. Or, conversely, the company pays, perhaps, the first $200 and the patient pays anything above that figure.

A card in Section 3, incidentally, should show only the third party's share of the bill. The card in Section 1 shows the patient's share. Both should carry cross-references. We think that it helps if you crimp color signals on the cards in Section 2 and 3 denoting the agency or company involved. Keyed to matching signals on your clinical charts, they'll speed identification of cards needed in a hurry—for a phone talk with a lawyer, maybe.

That's all there is to my system. Yet you'll find it makes the job of billing your patients as simple as it was in the days before medical plans. Bills to third parties for payment in full can be handled as a separate job on another day. It needn't interfere with the daily use of the other two sections of the file.

And, in cases where both the patient and a third party owe something on the same bill, you needn't wait for either one of them to pay up before nudging the other. The separate cards make it easy to bill them independently. END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and a bun
a snack for lunch and run? prescribe...
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When good nutrition takes second place, MYADEC will help prevent deficiencies by providing comprehensive vitamin-mineral support. Just one capsule a day provides therapeutic doses of nine important vitamins plus significant quantities of eleven essential minerals and trace elements.
Each MYADEC Capsule contains: VITAMINS: Vitamin B12 crystalline—5 mcg.; Vitamin B2 (riboflavin)—10 mg.; Vitamin B6 (pyridoxine hydrochloride)—2 mg.; Vitamin B1 mononitrate—10 mg.; Nicotinamide (niacinamide)—100 mg.; Vitamin C (ascorbic acid)—150 mg.; Vitamin A (7.5 mg.)—25,000 units; Vitamin D (25 mcg.)—1,000 units; Vitamin E (d-alpha-tocopheryl acetate concentrate)—5 I.U.; MINERALS: (as inorganic salts): Iodine—0.15 mg.; Manganese—1 mg.; Cobalt—0.1 mg.; Potassium—5 mg., Molybdenum—0.2 mg.; Iron—15 mg.; Copper—1 mg.; Zinc—1.5 mg.; Magnesium—6 mg.; Calcium—165 mg.; Phosphorus—80 mg. Bottles of 30, 100, and 250.
PARKE, DAVIS & COMPANY - DETROIT 32, MICHIGAN
PARKE-DAVIS

Your Surest Source Of Extra Income: Better Collections!

Continued from page 75

In addition, the ledger cards themselves weren't posted regularly. They were posted as and when his aide found time to do it. Sometimes she got as much as ten days behind. At month-end, no statements could be prepared until her postings had been brought up to date.

3. Make all charges known to the patient before recording them. The object is to give the patient a chance to ask questions —even to object to a charge— before he has to pay up. In Dr. Deshler's office, this was achieved by installing a charge-slip system. When his patients take the filled-in charge slips to the aide, they now know all the facts.

4. Give the patient a chance to pay at the time he receives service. When Dr. Deshler's aide is handed a filled-in charge slip, she announces the charge to the patient. If any other amount is owing for previous care, she also announces the up-to-date total. And she invites the patient to take care of the charges then and there. She never says: "Do you want me to send you a bill?"

5. Send statements on the last day of the month to every patient whose account shows a balance due—until three statements have been sent. Nowadays, Dr. Deshler's billing never spills over into the new month; nor is any account with an outstanding balance omitted from the month-end billing until (after three statements) the time comes for a different approach.

6. Realize that there's more to the maintenance of ledger accounts than the posting of debits and credits. In the box on pages 72-73, you'll find the advice I gave Dr. Deshler's aide—with his approval—on the details of keeping ledger accounts healthy.

Defining Delinquency

Now I had to help the doctor set up a corrective program for delinquent accounts. His first question, as you might expect, was: "*When* is an account de-

linquent?" I gave him the answer I give to all my clients:

"When you've had no response of any kind to three successive statements, you have a potential delinquent. Your job now is to bridge the gap between the third statement and the collection agency. The best bridge I know of is the U.S. Post Office."

I've known many medical offices to start letter systems—and to let them drop. Why the high mortality rate of these well-intentioned programs? For one thing, the doctor's aide is often too busy to keep her collection letters going out systematically. For another, there's a personal relationship between the doctor and his patients that can make collection letters seem distasteful.

So I usually recommend the letter service of a professional management firm, if such service is available. Dr. Deshler now uses such a service. But if there's no one around to do it for you, or if you prefer to handle your own program, here are the six things it takes:

Correcting Delinquency

1. Expertly written form letters. These must be in sufficient variety to cope with all but the most bizarre situations.

2. Clockwork production. If the letter-writing schedule isn't scrupulously followed, your program is bound to fail.

3. Limitation of effort. If three letters (after three statements) bring no response, don't flog a dead horse. The delinquent can now have no complaint if the account must be put into other hands.

4. A final warning. The delinquent is entitled to know that you're about to put his credit in jeopardy. A final letter should

Continued on page 188

"In spite of the enormous growth of the pharmaceutical industry and the tremendous investment that drug manufacturers put into research, the chances of their developing really new drugs that act along new principles . . . remain very small indeed. As a result only a very small fraction of the new preparations that are marketed each year represent such truly new drugs."

New England J. Med., Dec. 3, 1959, p. 1190.

Maltbie Laboratories is proud to announce such a truly new chemical entity: 1-m-aminophenyl-2-pyridone. Its name . . .

Dornwal®

for treatment of anxiety and tension without causing drowsiness

therapeutically outstanding: effectively interrupts tension headache / relieves acute emotional upsets / does not produce depression or depersonalization / is well suited to ambulatory patients / is virtually devoid of hypnotic or sedative activity / patients remain alert without undue stimulation /

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a tranquilizer with minimal side effects:
Look at the dramatically low incidence in an unselected group of 593 patients . . .

Symptoms	Patients	Symptoms	Patients
Drowsiness	9	Tinnitus	1
Sedation	2	Stimulation	3
Nausea	7	Insomnia	1
Pruritus	2	Dry mouth	8
Blurring vision	4	Exanthema	2
		Tremor	3

Dornwal

DROWSINESS WAS MINIMAL

(only 9 out of 593 patients: less than 2% . . . statistically not significant)

Prescribe Dornwal for your next patients who need a tranquilizer but cannot afford to be drowsy. Write for your trial supply.

Dornwal

Indications: anxiety and tension, various types of psychoneuroses, tension headache, menopausal syndrome, alcoholism, premenstrual tension, behavior problems in children.

Dosage: One or two 200 mg. tablets three times a day. Children, one or two 100 mg. tablets two times a day. Administration limited to three months duration.

Supply: 200 mg. yellow scored tablets, and 100 mg. pink tablets, each in bottles of 100 and 500.

No absolute contraindications to the use of Dornwal are known. There have been no reports or evidence of habituation, addiction or drug tolerance in animal or clinical studies. Dornwal has proved to be relatively free from untoward effects when administered at recommended dosage.

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POL-08

tell him that on a stated date you will send his account to a collection agency.

5. Follow-through. If, on the showdown date, you're unwilling to write the account off your books, automatic referral to the collection agency is all that remains.

6. A willingness to write off some accounts. What if you've reached the final step of calling in the collection agent, and you are reluctant to turn the account over? Then put it in the "Dead" file and forget it. You've exercised the one privilege that nobody wants doctors to forgo: the privilege of extending your charity.

It has been worth $10,000 to Dr. Deshler to carry out the twelve points of the two-part program I've described. But not much of the gain came from the six points of the second part. It came—and will continue to come—from the half-dozen rules for the *prevention* of delinquent accounts. That's how it will work in your case if you follow his example. END

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The combined action of the principal ingredients in Caroid and Bile Salts Tablets provides 3-way, physiologic relief of constipation.
Caroid® — potent proteolytic enzyme for improved protein digestion.
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Stimulaxant — to improve smooth muscle tone, restore regularity.

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in edema of pregnancy

"gratifying relief..."

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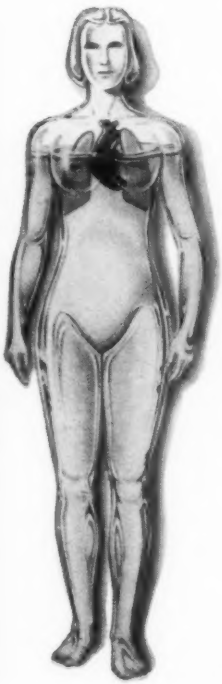
HYDROCHLOROTHIAZIDE

increased potency—without corresponding increase in side effects

Ford, Ralph V.: Southern Med. Jl. 52: 40, (Jan.) 1959

"Hydrochlorothiazide was given to patients with edema (mild to moderate) of varied etiology..." "There were...5 women in the third trimester of pregnancy." In these patients the cumulative weight loss was 2 pounds after seven days of therapy and 4 pounds after twenty-one days. Gratifying relief of edema was observed in all patients.



DOSAGE: One or two 50 mg. tablets HYDRODIURIL once or twice a day, depending upon the condition and individual patient response.

SUPPLIED: 25 mg. and 50 mg. scored tablets HYDRODIURIL (Hydrochlorothiazide) in bottles of 100 and 1,000.

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MSD MERCK SHARP & DOHME
Division of Merck & Co., INC. Philadelphia 1, Pa.

Malpractice Threat Is Changing Medicine

Continued from page 83

I feel it might be valuable and worth trying," a Pennsylvania ophthalmologist says flatly.

"I'm careful to use only fully accepted methods and drugs, pioneering in nothing," says a New York anesthesiologist. "My overwhelming consideration is *safety*."

A New York surgeon agrees: "Good medicine is no longer as important to me as *safe* medicine," he says. "For example, I now use aortography much less often than it's clinically indicated simply because of the litigation that has followed its complications."

And a Tennessee orthopedic surgeon sums up his attitude this way: "I definitely have become more selective about what procedures I'll try. Some of the more difficult and extensive operations that I'd have proposed unequivocally five or ten years ago, I now suggest only to an occasional patient who I feel is intelligent enough to understand the risks involved."

Nearly one doctor-respondent in four reports ways other than those listed on the questionnaire in which his practice is being affected by the mounting threat of malpractice claims. Anesthesiologists mentioned one change time and again. Not only are they shying away from spinal anesthesia; many say they're letting the patient decide what type of anesthesia he'll have.

The Patient Prescribes

"I often give in to patients' requests for a certain type of anesthesia against my better judgment, thus permitting them to practice medicine," a New York man admits. "If I wish to give a spinal in an emergency and the patient refuses, I don't even attempt to talk him into it."

"I never use spinal anesthesia, often the technique of choice, unless all other methods are strongly contraindicated," a Washington State man says. "I feel I have to accede to patients'

desires more often, even when they go against sound clinical reasoning."

"Nowadays, it's almost easier for an anesthesiologist to face a death under general anesthesia than to face a simple postspinal headache," a New Jersey man says wryly. And a Maryland anesthesiologist's comment explains why:

"Although complications from spinal anesthesia are very rare," he says, "they've had so much publicity in the lay press that I've quit giving spinals entirely. Jury awards in these cases have been just too damned unreasonable!"

Here are other doctors' comments that shed more light on what effect the malpractice threat is having:

M.D.s Anonymous

"I will *not* have an M.D. tag on my car," a Texas internist says. "I took it off because I don't wish to be recognized as a physician. I avoid the scene of auto accidents whenever possible."

"I shy away from all accident cases," a Michigan surgeon states. "I even refuse to check on accident patients in the hospital emergency room."

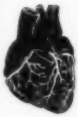
Says a New Jersey G.P.: "I'm extremely careful now about getting a colleague to cover for me when I'm out of town for even a short time. I keep one eye on medicine and the other on a subpoena."

Signed Protection

"I now have parents sign 'forms of understanding' for nearly all procedures I undertake," a Pennsylvania pediatrician says. "These forms state that they have full knowledge of what procedures I intend to use with their children and of what my diagnosis and prognosis of the case is."

"If I undertake even such routine procedures as allergy injections, immunizations, and influenza injections, I now do so with such caution that they often require two or even three extra office visits," a New York pediatrician reports.

"I shy away from prophylactic surgery, such as removing an ap-



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1. Melville, K. I., and Lu, F. C.: Canadian M.A.J., *65*:11, 1951. 2. Bovet, D., and Nitti-Bovet, F.: Arch Internat. de pharmacodyn. et therap., *83*:367, 1946. 3. Fuller, H. L., and Kassel, L. E.: Antibiotic Med. & Clin. Therapy, *3*:322, 1956.

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pendix during a hysterectomy," a New York gynecologist says. "And I even avoid certain difficult procedures that I believe really *should* be performed despite their risk."

And a Connecticut plastic surgeon reports: "I won't do face lifts for women who request them in hopes they'll help solve marital difficulties. I know from experience that such patients have unrealistic expectations about what these operations can accomplish."

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evitably to one double-edged conclusion:

The threat of malpractice suits has made many doctors more careful about the kind of medicine they practice. There's little doubt that better—if more costly—care is being rendered by the G.P. who now refers cases he's not sure of, the internist who orders all the diagnostic tests necessary, and the pediatrician who asks for consultations on doubtful cases.

But the malpractice threat has also made many doctors ultracautious. Is better medicine being practiced by the G.P. who now has his patients sprayed with needless X-rays, the surgeon who'll no longer risk difficult but clinically desirable procedures, and the anesthesiologist who now shuns spinals even when they're the "technique of choice"?

We'll see why some doctors say these changes are lowering the quality of care patients get—and hurting the practice of medicine in general—in a future issue. END

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WHENEVER A DIAPHRAGM IS INDICATED

Memo

From the Editors

The Impact of Ideas

On the floor of Congress a few years ago, Representative Louis B. Heller told about a conversation he'd had with a prominent New York surgeon. "In the course of our talk," Mr. Heller informed his fellow legislators, "he called to my attention an article which appeared in . . . MEDICAL ECONOMICS. [The article] proposed a Federal school for physicians—that is, a West Point of medicine . . . I thought so well of this idea that I have this day introduced a bill to create a medical academy."

We mention this incident because it neatly illustrates what we consider the basic function of MEDICAL ECONOMICS: to serve as a clearinghouse of ideas. Sometimes outsiders get in on the act. More often, the idea-trading remains wholly within the profession. So the impact of these ideas can often be judged by their ripple effect in other professional publications. Almost any random sampling turns up examples like these:

¶ In the Journal of the Michigan State Medical Society, an editorial urges members to read MEDICAL ECONOMICS' recent articles on progressive hospital care. "They are eye openers," says the editorial. "We have had many comments and queries already."

¶ In the American Society of Internal Medicine's newsletter, Dr. Clark C. Goss begins his President's Column: "I hope you have all read the article appearing on page 98 in the [latest] issue of MEDICAL ECONOMICS . . . If any of us does not already have the opinion that our fee system has been chaotic, unrealistic, and immature, this article will convince him."

¶ In the Menninger Clinic Bulletin, Dr. Karl Menninger writes: "MEDICAL ECONOMICS does a great service for doctors. A few of the items in the [latest] issue that impressed me . . ." And then Dr. Menninger comments on the ideas contained in seven feature articles and one news item—all from the same issue of this magazine.

¶ In the New York State Journal of Medicine, a committee report says: "Dr. John C. McClintock, chairman, discussed the new Medicare fee schedule at length. He quoted from five letters, two telegrams, and an article in MEDICAL ECONOMICS . . . He moved to rescind Council action to publish Medicare fees . . . The motion was passed." END

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*Draize, J.H., Dermal Toxicity, Food Drug Cosmetic Law J., 10:722-732 (Oct.) 1955. (Above test is a slight modification of the one described in reference.)

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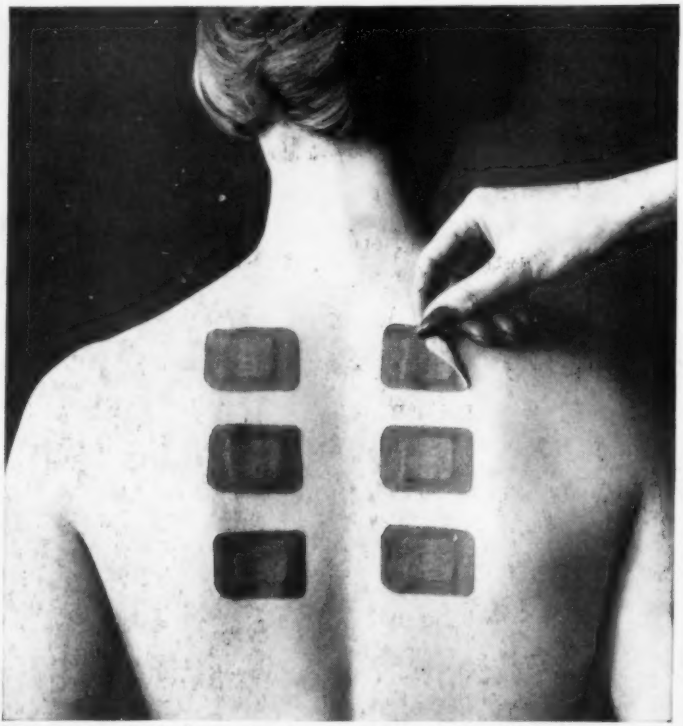

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